The Dissertation Committee for Haskell Stephen Cooper

certifies that this is the approved version of the following dissertation:

Interorganizational Relationships Among Providers of Public Social Services for Emotionally Disturbed Children in Rural East Texas

Committee:

David W. Springer, Supervisor

Michael L. Lauderdale

Dennis L. Poole

T. Laine Scales

Calvin L. Streeter

Interorganizational Relationships Among Providers of Public Social Services for Emotionally Disturbed Children in Rural East Texas

by

Haskell Stephen Cooper, B.S.; M.S.W.

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DEDICATION

As I began writing the dedication, I quickly realized that it would be the easiest, as well as the most difficult part of this dissertation to write. On one hand, it is easy to reflect on my life and, without hesitation, identify those who shaped me into who I am today. On the other hand, it is difficult to convey in words the tremendous amount of respect and appreciation I have for those individuals. It is my hope that dedicating this dissertation to my parents, wife and son will convey my gratitude. Without their love, encouragement, support, and guidance, I would not have embarked on this journey, much less completed it.

My parents, Hayden H. and Judith A. Cooper, instilled many of the values and beliefs that have guided my decisions and supported me through life's little "bumps." Most importantly, they taught me compassion, fairness, empathy, unconditional respect for others, and the importance of family. My father played a pivotal role in my development of problem solving and writing skills. More often than not, his response to my childhood questions was "Go look it up in the encyclopedia/dictionary and then come back." He never "gave" me an answer, but he always helped me find one. Although my father passed away before I graduated from college, the lessons he taught me have remained. I hope that he knows how much I love and appreciate him. For as long as I can remember, my mother has been a significant source of support. She always knows when to offer encouragement and is quick to express how proud she is of me. More importantly, she has always been there when I needed her. Always. Thanks mom.

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Interorganizational Relationships Among Providers of Public Social Services for Emotionally Disturbed Children in Rural East Texas

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Supervisor: David W. Springer

The primary providers of services to Texas children with emotional/behavioral issues are local juvenile probation departments, Texas Youth Commission, Department of Family and Protective Services, local Mental Health Authorities, and school districts. These agencies currently face a variety of issues that impede their ability to deliver effective services. Responses to these issues have included narrowing eligibility criteria and imposing limits on the number of clients served at one time. Unfortunately, many of the individuals who need assistance are unable to access services and eventually find themselves in other less appropriate systems, such as foster care and juvenile justice. This is especially true for rural areas, which often lack the resources found in urban counties. Many believe the solution involves closing the "gaps" in services through interorganizational relationships. However, cooperative efforts require a substantial amount of commitment, time, effort and resources. More often than not, this is a difficult endeavor, especially given the barriers to rural service delivery, funding issues, and state level issues.

Concept Mapping was employed to identify and assess the impact of factors that affect service providers' ability to engage in interorganizational relationships, as well as deliver services to children who are at risk of or possess emotional/behavioral issues.

Concept Mapping is a mixed methods approach capable of identifying the specific domains of a larger conceptual framework. The results can enhance our understanding of the concept and inform planning and evaluation activities. Forty-eight individuals from rural East Texas participated in various stages of the study, resulting in the identification of 118 factors that were subsequently sorted into six conceptual domains and rated in terms of importance and response (encouraging or discouraging). Participants also provided narrative responses regarding service delivery situations, components to change and keep the same, and perceptions of the system's capacity for change. Key findings include the identification of specific factors that affect interorganizational relationships and service delivery, as well as potential changes to the current social services system. Also, consistency among respondents suggests the climate is conducive to cooperation. The results are discussed in the context of implications for interorganizational relationships and service delivery.

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CHAPTER 1- INTRODUCTION

Texans possess a remarkable sense of pride in their state and are quick to point out its many positive qualities, such as its natural beauty, geographic diversity, variety of options for outdoor enthusiasts, cultural diversity, colorful history, and broad economic base. Texas pride is often exemplified by catchy slogans, such as "Don't Mess with Texas" and "Things are Bigger in Texas." The later slogan describes many aspects of Texas, including the population of children under 18 years of age, which for 2002 was estimated to be 5.9 million and was expected to increase over the next decade by approximately 8% or a half-million children (U.S. Census Bureau, as cited in McCown & Castro, 2004b). Unfortunately, the slogan also describes the severity of social problems faced by Texas children.

The number of Texas children living in poverty has steadily increased since 2000 (Deviney, 2005; Legislative Budget Board, 2006; McCown & Castro, 2004b). In 2001, 21% of Texas children lived below the federal poverty line, earning Texas 44th place in the national rankings (McCown & Castro, 2004b). The current rate is 23.6%, which exceeds the national average of 17.8% and places Texas 5th in the nation in terms of highest childhood poverty rates (Hagert, 2006). Related social issues that impact Texas' children include, but are not limited to, lower wages (Lavine, 2004), lower family incomes (Deviney, 2005; Lavine, 2004), underemployment (Deviney, 2005; Finet, 2002), a teen birth rate that exceeds the national average by more than 50% (Finet, 2004), limited access to public assistance (Deviney, 2005; Hagert, 2006) and a high school dropout rate that exceeds the national rate by 33% (Finet, 2004). In fact, 10% of those ages 16-19 are not attending school and are unemployed (Annie E. Casey Foundation, 2004). Furthermore, 20% of Texas' young adults are disconnected (possess no more than a high school diploma, are not in school, and are unemployed), a rate that is 5% higher than the national average (Annie E. Casey Foundation, 2004). Texas has been ranked 50th in the nation five consecutive years for the highest percentage of children (21%) without health insurance (Deviney, 2005; Finet, 2004). Finally, the Texas Department of Mental Health and Mental Retardation (TDMHMR) estimated that by 2005 more than 1.2

million (or 20%) of Texas' children will present with or be at-risk of mental health problems (2003). All of these factors, as well as others, have contributed to Texas' drop in national ranking from 36th to 39th for overall child well-being (Annie E. Casey Foundation, 2004, 2006).

Given the presence of various social problems and threats to child well-being, one would assume that Texas would concentrate a significant amount of resources on alleviating such issues. However, just the opposite has occurred. Social services and related funding for children, as well as adults, have been steadily reduced over the past decade. According to the Mental Health Association of Texas (MHAT), the mental health system has been plagued by "chronic underfunding and penny-pinching" resulting in the lack of adequate mental health services (2005, p. 2-17). In 2002, Texas was ranked 49th in the nation for per capita spending on mental health services (MHAT, 2005). Prior to 2003, less than 28% of Texas children with mental health issues were eligible for state funded mental health services and only 25% of those who were eligible received services (MHAT, 2005). The number of adults and children served in Texas' mental health system were further decreased in 2004 due to additional budget cuts and service reductions.

The aforementioned changes are expected to be followed by an increase in mental health crisis situations requiring inpatient hospitalization (MHAT, 2005). The number of people with mental illness in other services or systems, such as emergency rooms, schools, foster care, jail, prison, and homeless shelters is also expected to increase (MHAT, 2005). Unfortunately, most of these systems are not equipped to meet the specific needs of individuals with mental illness. In fact, many of them, including prevention and early intervention programs, juvenile probation, Texas Youth Commission, Child Protective Services, and public schools have experienced significant reductions in funding and other resources. Simply, community-based services for children are unprepared to prevent and address the issues faced by children. More importantly, in many cases the inadequacy of services all but ensures that the child's situation will worsen, possibly to the point of requiring intensive community-based or residential treatment.

Reductions in mental health services have increased the burden placed on local governments and social service organizations, such as schools, foster care, juvenile probation, hospitals, and community clinics. Some urban Texas counties have been able to muster financial resources to bolster their local mental health authorities (MHA) and provide mental health services through other organizations. For example, Harris County (Houston) spent $22,786,886 to support its MHA during the 2004 fiscal year (MHAT, 2005). During the 2003 fiscal year, Dallas County (Dallas) spent $4,781,306 to provide mental health services via its Health and Social Service's Department (MHAT, 2005). Unfortunately most rural counties do not possess the financial resources (i.e., tax base) to supplement the mental health services provided by the local MHA. Furthermore, rural counties typically lack the multitude of private and non-profit social service organizations often found in urban counties. Thus, in rural areas the MHAs, juvenile probation departments, child protective services, and schools are left without adequate resources to provide children with the support they need to become stable and independent adults who are able to contribute to the community. Given this, the specific aims of the study were to examine the impact of the children's social services system upon the delivery of services to rural East Texas children who are at risk or possess emotional/behavioral issues and to utilize the knowledge gained to inform policy decisions regarding the delivery of services to this population.

Statement of the Problem

For the purposes of this dissertation, children with emotional/behavioral issues are defined as those who meet the following "priority population" criteria set by the Texas Department of State Health Services (TDSHS):

> children and adolescents ages 3 through 17 years with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who: 1) have a serious functional impairment (GAF of 50 or less currently or in the past year); or 2) are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or 3) are enrolled in a school system's special education program because of a serious emotional disturbance (TDSHS, 2005).

Based on the above definition, children who are solely diagnosed with autism or another pervasive developmental disorder, mental retardation, or substance abuse are not considered a member of the priority population (TDSHS, 2005). The primary providers of services to Texas children with emotional/behavioral issues are the local juvenile probation departments, Texas Youth Commission, Department of Family and Protective Services, local Mental Health Authorities, and school districts. This is especially true for rural areas where services are often limited to those mandated or provided by the State. A brief overview of each system's responsibilities and limitations follows:

- Juvenile Probation- Juvenile probation services are limited to children between the ages of 10 and 17 who have engaged in conduct indicating a need for supervision (CINS) or delinquent conduct. This excludes children under the age of 10 who present with significant conduct issues and those over 10 years of age whose conduct is not severe enough to warrant referral to juvenile probation. Instead, they may be referred to community mental health services, CPS, and/or school based services. Unfortunately many of them do not receive services until their behavior warrants formal attention from the juvenile justice system, which is due in part to the eligibility criteria for CPS and community mental health services.
- Texas Youth Commission (TYC)- TYC serves children who are committed by a judge as a result of a felony offense committed between the ages of 10 and 17. Currently the most significant challenges for TYC are the provision of adequate and effective inpatient and parole services. In terms of parole services, one of the major limitations facing TYC is the lack of community based supports and services for children. The absence of such resources greatly increases the likelihood the child will commit additional offenses resulting in parole revocation. It is important to note that many of TYC's inpatient facilities are located in rural areas.
- Child Protective Services (CPS)- Child protective services are provided by the Department of Family and Protective Services (DFPS) (formerly known as the Department of Protective and Regulatory Services). CPS serves children

from birth up to 17 years of age who are abused or neglected. While CPS is charged with serving children up to 17 years of age, there is a noticeable tendency to defer children 10 years and older, whose behaviors are related to inadequate supervision, to the juvenile justice system. The issue is that the juvenile probation departments are unable to address such issues unless the behavior constitutes either CINS or delinquent conduct, whereas it is within the scope of CPS to address such behaviors. Again, this creates a situation where many children do not receive services until their behavior warrants attention from the juvenile justice system.

- Mental Health Authorities (MHA)- The local MHA is responsible for serving children and adolescents who meet the "priority population" criteria outlined earlier in this section. Due to reductions in services and resources, children who qualify for services may have to wait up to a year for an opening, greatly increasing the likelihood their condition will worsen. Children who are not eligible must either find other services in the community or go without services, placing them at-risk of deterioration and/or involvement with other systems, such as juvenile justice.
- School Districts- Primary and secondary schools are mandated to provide services to children who are identified as Emotionally Disturbed (ED), a label that is assigned by the school district when it is determined that a child's emotional or behavioral issues interfere with his/her ability to succeed academically. Once a student is identified as ED, the school is required to deliver educational services to the student that are consistent with his/her needs. Such services are to be provided in the least restrictive environment and may include a variety of classroom modifications and support services, such as mental health services.

As indicated by the preceding descriptions, narrow eligibility criteria limit services to those children who experience the most severe issues. For example, the eligibility criteria for children's community mental health services exclude those with minor mental health issues, many of which will worsen with time, especially for those

who are unable to afford private mental health services. Even those who qualify for services may have to wait for services, sometimes up to a year, due to the state imposed limits on the number of clients who can be served with state funds. The length one must wait for services is expected to increase based on estimates that spending per capita and the number of mental health clients served during the fiscal year of 2005 will be less than previous years (MHAT, 2005). It is estimated that only 27% of eligible individuals will receive services (MHAT, 2005). More importantly, those who are eligible, commonly referred to as the "priority" or "target" population, only constitute 15% of the Texas citizens who are diagnosed with a mental illness (MHAT, 2005). Again, this creates a situation where individuals find themselves getting progressively worse before they are able to access services.

Individuals who are unable to access mental health services are at increased risk of engaging in behavior that warrants involvement with the criminal justice system (MHAT, 2005; Sage, 2006; U.S. Department of Health and Human Services, 2000). Many children with mental health issues escalate to the point of formal referral to the juvenile justice system and in some cases commitment to TYC. Schwank, Espinosa, and Tolbert (2003) found that 47.5% of the juveniles sampled (n=62,821) during the 2002 fiscal year reported the presence of at least one mental health disorder. An additional study (n=1,009) found that approximately 13% had recently experienced suicidal ideation and 13.7% reported having attempted suicide during their lifetime (Schwank et al., 2003). During the 2006 fiscal year, of those committed to TYC, 41% presented serious mental health issues, 46% were identified as chemically dependent, and 40% meet the criteria for special education services (TYC, 2007f). Children entering TYC who have a mental health issue may require placement in a special program at Corsicana State School, at an additional cost of $200 per day. Additional support is offered by the Mental Health Association of Texas,

> In the last 10 years, the proportion of youth with serious mental health problems at time of commitment to the Texas Youth Commission (TYC) has increased from 27 percent to 42 percent. Their mental health needs are deeply intertwined with their delinquency and are often further compounded by substance abuse.

> The absence of adequate mental health services during their developmental years undoubtedly contributed to their eventual involvement with the juvenile justice system. The juvenile system now mirrors the adult system with more individuals with mental problems in criminal systems that in mental health systems (2005, p. 5-15).

Unfortunately the prevalence of mental health disorders and related issues among juvenile delinquents is not limited to Texas; they are present across the nation (Abram, Teplin, Charles, Longworth, McClelland, & Dulcan, 2004; Abram, Teplin, McClelland, & Dulcan, 2003; McClelland, Elkington, Teplin, & Abram, 2004; Roberts & Corcoran, 2005; Skowyra, 2006; Skowyra & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Teplin, Abram, McClelland, Mericle, Dulcan, & Washburn, 2006; Teplin, Abram, McClelland, Washburn, & Pikus, 2005; Teplin, Elkington, McClelland, Abram, Mericle, & Washburn, 2005; U.S. Department of Health and Human Services, 2000).

Another alarming trend is the use of Texas' foster care system as a mental health service provider by families who are unable to access mental health services for their child(ren). According to MHAT (2005), each year parents of approximately 250 Texas children terminate their parental rights in order to access mental health care via the foster care system. A related trend involves parents deliberately seeking juvenile justice services in order to access mental health services (Sage, 2006). In Texas, Dallas County and Harris County each estimated placing 200 children in the juvenile justice system during 2001 for the purpose of accessing mental health services (United States General Accounting Office, 2003). Nationally, the use of child protective services and juvenile justice services to access mental healthcare resulted in the placement of 12,700 children during 2001 (United States General Accounting Office, 2003). While some states have chosen to implement policies to prevent such placements, for such policies to be effective, comprehensive community-based services must be provided to these families (Dababnah & Cooper, 2006; United States General Accounting Office, 2003).

The solution to this problem obviously involves closing the "gaps" via expansion of existing eligibility criteria and services, extensive aftercare services, and cooperation

among service providers. Expansion of prevention and early intervention services should also be considered given the previously reported estimates of children that are at risk of a mental health issue. Implementing such changes would help alleviate the common situation where a child's condition must worsen before he/she is eligible for public services. However, the solution must also address the underlying issue of funding availability. State and local budget cuts have significantly reduced the funds available to primary service providers, bringing an increase in competition for resources, interorganizational animosity, and reluctance to cooperate with one another. These conditions encourage a shift in group behavior from working collaboratively to close service "gaps" to active avoidance of responsibility and "finger pointing," both of which effectively widen the "gaps." In addition to being detrimental to collaborative efforts, such as the CRCGs (Community Resource Coordination Groups) (Springer, Sharp, & Foy, 2000), limited resources and funding cuts are often accompanied by reductions in prevention and early intervention programs. For example, in 2005 STAR (Services to At-Risk Youth), a program that provides services to at-risk youth who are not eligible for juvenile probation and child protective services, faced a 25% cut ($9.4 million) over the next two years (Greater San Marcos Youth Council, 2005). This cut followed a 25% cut as a result of HB 2292 in 2003. Such funding cuts are unfortunate given the broad impact and cost-effectiveness of early intervention services and community-based interventions (MHAT, 2005).

Despite the aforementioned barriers to collaboration, some efforts have been successful. One such effort, the Special Needs Diversionary Program (SNDP), was initiated when the 77th Texas Legislative Session appropriated $4 million to TJPC and $10 million to the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI), which was formerly the Texas Council on Offenders with Mental Impairments (TCOMI) (Schwank et al., 2003; TJPC, 2007). The funds were used to support the development and implementation of SNDP, a collaborative effort among TJPC, TCOOMMI, and TDMHMR (Schwank et al., 2003). SNDP is loosely based on MST (multisystemic therapy), a treatment model developed by Henggeler and Borduin (for more details see Henggeler & Borduin, 1990 and Henggeler, Schoenwald, Borduin,

Rowland, & Cunningham, 1998). The purpose of SNDP is to reduce juvenile justice system contacts and out-of-home placements of juveniles with mental health needs through collaborative community-based services. Specifically, local juvenile probation departments and the local MHA form a partnership to provide intensive services to clients. Services, including family therapy, individual therapy, rehabilitation services, skills training, and chemical dependency education are delivered by a team consisting of a therapist (at least a Masters level licensed mental health professional) and a case manager who carry a caseload of 12-15 clients. The low caseload is due to the expectation of 3-5 face-to-face contacts per week with the client and family, with at least two of them occurring at home. Currently, SNDP is offered in 19 geographical areas across Texas and initial data indicates the program has promise, both in terms of treating juveniles in the community and cost-effectiveness (Schwank et al., 2003; TJPC, 2007). However, the implementation of this program in rural areas has been difficult due to a variety of barriers, including geography, culture, language, and recruitment and retention of qualified personnel. Unfortunately, the barriers to rural service delivery experienced by SNDP are not uncommon.

When comparing urban and rural areas in terms of social issues, one can identify many common threads, such as poverty, inadequate housing and healthcare, crime, juvenile delinquency, domestic violence, and discrimination. In fact, urban and rural areas appear to be similar in terms of the degree of functional impairments (Walrath, Miech, Holden, Manteuffel, Santiago, & Leaf, 2003) and prevalence of psychiatric disorders (Deirker, Solomon, Johnson, Smith, & Farrell, 2004; Judd, Fraser, Grigg, Scopelliti, Hodgins, Donoghue et al., 2002). The difference between the areas lies in additional factors that exacerbate these issues in rural areas, including lack of economic opportunity, limited resources, scarcity of trained professionals, socio-economic underdevelopment, geographical isolation, physical distance from services, dependence upon private transportation, lack of public transportation, limited financial resources, and archaic technology (Carlton-LaNey, Edwards, & Reid, 1999; Daley & Avant, 1999; Ginsberg, 1993, 1998; Judd et al., 2002; Nooe & Bolitho, 1982; Roberts, Battaglia, Smithpeter & Epstein, 1999; Scales & Cooper, 1999; Stephen F. Austin State University

School of Social Work, 2001; Stuart, 2004; Templeman & Mitchell, 2004; Van Hook & Ford, 1998; Van Wart, Rahm, & Sanders, 2000; Wiesheit, Falcone, & Wells, 1999; Whitaker, 1984). The effects of these factors are present in many areas, including a rural area of East Texas commonly referred to as Deep East Texas.

The Deep East Texas region is located south of Tyler and Longview, north of Houston and Beaumont, and adjacent to Louisiana's western border. The region consists of 12 rural counties that cover a total of 9,906 square miles (U.S. Census Bureau, 2006) and possesses the following characteristics: below the state average for residents per square mile (U.S. Census Bureau, 2006), overrepresentation of African Americans when compared to the state average (U.S. Census Bureau, 2006), high school and college completion rates below state average (U.S. Census Bureau, 2000, 2006), individual and family poverty rates higher than the state average (U.S. Census Bureau, 2000, 2006), limited availability of public services and resources (public housing, healthcare, mental healthcare, substance abuse services, inpatient psychiatric services, domestic violence shelters, and emergency shelters), centralized mental health and substance abuse education/treatment services (requiring extensive travel), and unstable employment market and economy due to a limited economic base that is heavily dependent upon agriculturally related industries. Basically, there are fewer resources in rural areas to address social issues and those that are in place face a variety of challenges. It is important to note that the term rural describes any geographical area that is not located within an urbanized area, a census block or group of blocks with a minimum population density of 1,000 people per square mile, or urban cluster, census blocks with a minimum population density that are adjacent to an urbanized area (Daley & Avant, 2004; Olaveson, Conway, & Shaver, 2004; U.S. Census Bureau, 2002).

In summary, Texas' current social service system is ill equipped to address the variety and severity of issues found among children with emotional/behavioral issues. The problem appears to be driven by three key issues:

1. Fragmentation of state mandated services resulting in lack of coordination and cooperation among service providers.

2. Lack of funding and resources to support the delivery of adequate state mandated services to children (community mental health, inpatient psychiatric hospitalization, juvenile probation, institutional commitments to TYC, child protective services, and educational services).
3. Limited capacity of local communities and service providers, especially in rural areas, to cover gaps in services and address client needs.

In addition to impacting children, the above issues exacerbate family, organizational, and community issues. This is especially true for rural areas, which face a variety of unique challenges to service accessibility and delivery. While the solution for rural areas appears to involve expanding the scope of children's services, this cannot be accomplished without developing a better understanding of the issues in the context of rural areas.

Purpose of the Study

A variety of studies, reports, and resources regarding the challenges faced by Texas children with emotional/behavioral issues and related difficulties in delivering social services are available (Hogg Foundation for Mental Health, 2004a, 2004b; McCown & Castro, 2004a, 2004b; MHAT, 2005; National Mental Health Association, 2003; Osher & Shufelt, 2006; Schwank et al., 2003; Springer, Sharp, & Foy, 2000; Strayhorn, 2004a, 2004b; Texas Comptroller of Public Accounts, 1996). However, most of them examine the issues in urban areas with limited attention, if any at all, given to rural areas. As previously mentioned, rural areas face unique issues, including but not limited to social and economic underdevelopment, limited resources, geographical barriers, isolation, and difficulties with recruiting and retaining trained professionals. Rural areas also possess unique strengths, such as natural helping networks, strong "sense of community," intimacy and interdependence among residents, emphasis on self-sufficiency, abundance of personal space, strong family values, faith-based organizations, family oriented business practices, internal focus or interdependence and intergenerational thinking (Judd et al., 2002; Nooe & Bolitho, 1982; Stephen F. Austin State University School of Social Work, 2001; Templeman & Mitchell, 2004). Finally,

rural areas have some characteristics that may serve as either strengths or challenges, depending on the situation. Examples include informal decision-making, informal power structures, slower pace of life, emphasis on traditional values, preference for acceptance over individuality, geographical isolation, and closed to outside influence. For instance, is it geographical isolation or plenty of personal space? Is it independence or resistance to outsiders?

Given the differences in strengths and challenges between rural and urban areas, one cannot assume that the two areas will experience an issue in the same manner. Nor can one assume that a solution formulated to address an issue in an urban area is immediately applicable to the same issue in a rural area. In other words, formulating a solution for service delivery issues in a rural area requires an in depth understanding of the issues facing that particular community or region. Therefore, the specific aim of the study was to examine the impact of the children's social services system upon the delivery of services to rural East Texas children who are either at-risk of or possess emotional/behavioral issues. Specifically, the study seeks to answer the following research questions:

1. *How does the current structure of public social services for children who are at risk of or possess emotional/behavioral issues affect the ability of service providers to develop and maintain interorganizational relationships?*
2. *How does the current structure of public social services for children who are at risk of or possess emotional/behavioral issues affect service delivery to rural East Texas clients and their families?*

In addition to the implications for service delivery in rural areas and children with emotional/behavioral issues, this dissertation has the potential to address other deficits in the knowledge base. For instance, currently there is a lack of information regarding needs, duplications, gaps, and costs of mental health services (MHAT, 2005). Although this dissertation was not designed to assess costs, it has generated information about needs, gaps, and duplications in children's services related to mental health. While most of the current studies either focus on organizations, service providers or clients, this dissertation sought input from direct service providers, supervisors, administrators, and

parents of clients. Furthermore, Concept Mapping, the methodology used in this study, allows for multiple comparisons between the stakeholder groups, resulting in the identification of points of consensus and disagreement. The collection and application of such information is vital to planning and implementing change in service delivery systems and is congruent with social work values and interventions. Finally, the author is hopeful that the results will spark and inform a shift from the current focus on cost-cutting and immediate savings to one that addresses both short and long term issues, including the overuse of and increasing burden placed on local emergency rooms, healthcare providers, law enforcement agencies, community-based corrections, county jails, juvenile detention centers, prisons, courts, schools, child protective services, local mental health authorities, the state psychiatric hospital system, and public assistance programs.

CHAPTER 2- LITERATURE REVIEW

Interorganizational Relationships

As community resources continue to dwindle and social issues become more complex and prevalent, human services organizations are finding it increasingly difficult to meet the demand for comprehensive services (Linden, 2002; Springer et al., 2000). For example, clients such as the elderly and chronically ill require a variety of services that are usually not offered by a single service provider (Raak & Paulus, 2001). The delivery of human services is further impacted by current attitudes regarding a reduction in the structure, roles, and responsibilities of government in the provision of human services, as well as a shift in such to the private sector (Snavely & Tracy, 2000; Springer et al., 2000). TANF exemplifies such attitudes through its inherent assumption that "nonprofit organizations and businesses will take on greater responsibility to provide jobs and social supports to the poor and unemployed" (Snavely & Tracy, 2000, p. 147). The government's shift or move away from the role of human service provider is often referred to as devolution or governance vs. government (Cloke, Milbourne, & Widdowfield, 2000; Jones & Little, 2000; Poole, 2003; Poole, Ferguson, DiNitto, & Schwab, 2002; Springer et al., 2000). While this obviously affects local human service organizations, there are also implications for local government. Specifically, devolution and governance include an expectation that local government and organizations will work together in the creation and implementation of policy, as well as service delivery (Cloke et al., 2000; Poole, 2003; Springer et al., 2000). Hanf (1987) notes that organizations must work together because social problems tend to fall within the boundaries of multiple organizations and social policy development through implementation involves multiple organizations (as cited in Reitan, 1998). Additional factors that encourage human service organizations to work together include fragmentation of services, governmental mandates, an assumption that collaboration reduces costs of service delivery, management of specialized services, disappearance of interorganizational boundaries, and increases in interorganizational trust (Agranoff & McGuire, 1999; Hodges, Hernandez, & Nessman, 2003; Okamoto, 2001; Reitan, 1998; Walter & Petr, 2000).

Since interorganizational relationships provide the means for focusing a variety of resources from multiple sectors on the alleviation of social issues, they are often hailed as a viable alternative to the rigid and seemingly ineffective bureaucratic model of government social service delivery (Snavely & Tracy, 2000). However, successful management of such relationships or networks is much easier said than done. The involvement of multiple players with various philosophies, interests, motivations, goals, standards, expectations, governing organizations, service delivery methods, and internal dynamics creates a situation primed for conflict. The formulation and maintenance of networks is further influenced by the tendency of human service organizations to be technologically disadvantaged, to lack adequate knowledge for goal accomplishment, and to operate with confusing or incompatible goals (Dickens, 1996, as cited in Reitan, 1998). Successful relationships require the management of all these factors and consensus regarding division of labor, supervision and coordination of daily operations, and service delivery (Raak & Paulus, 2001). Given all of these factors, it becomes obvious that interorganizational relationships and management of the resulting networks encompass a variety of concepts, components, skills, competencies, and challenges, many of which are not addressed by earlier organizational management theories, especially those based on closed systems theory. The absence of such information has encouraged a variety of disciplines and researchers to investigate the various aspects of interorganizational relationships. The following sections will provide an overview of recent literature with specific emphasis placed on the key theories regarding interorganizational relationships, the types of interorganizational relationships, collaboration and its components, barriers to collaboration, the practical application of collaboration, and an overview of children's social services in Texas.

Perspectives and Theories Relevant to Interorganizational Relationships

The current interest in interorganizational relationships has been accompanied by an increase in organizational theories that address issues related to such relationships (Reitan, 1998). Since many disciplines are involved in organizational management and there is not an agreed upon manner in which to approach this topic, there are significant

variations among the theories. For instance, they tend to vary in their point of view, unit of analysis, purpose (e.g., prescriptive or descriptive), and applicability to human service organizations (Reitan, 1998). Although several of the organizational theories are fairly comprehensive, it is important to keep in mind that "no particular theory can provide an unyielding, correct framework for analyzing problems" (Reitan, 1998, p. 286). While it is outside the scope of this dissertation to discuss each of the relevant organizational perspectives and theories in depth, a brief summary for each of the key perspectives and theories is provided as a springboard for subsequent discussion.

Client Need Perspective

The main roles of modern government are political entity and service provider, with the later becoming increasingly more important, especially for local government (Reitan, 1998). The role of service provider requires a model that emphasizes a direct connection between the issue and the policy, as well as accountability to constituents (Reitan, 1998). Specifically, the government or service provider is to be held accountable for meeting the needs of its constituents or in this context, its clients. As previously mentioned, the multiple needs of clients require a variety of services, many of which cannot be reasonably provided by one organization. Therefore, accountability is dependent upon interorganizational relationships. Reitan (1998) makes an interesting observation regarding the role of government as service provider,

> …focusing on client needs as the basis for interorganizational interaction casts light on the fundamentally political and democratic aspects of service delivery. Because clients are also voters, the system's ability to respond influences its viability, which reflects the interrelations between political and service delivery functions (p. 288-289).

Professional Perspective

The professional perspective examines interorganizational relations in the context of professions, professional groups, and professional roles. The premise being that organizations are impacted by the struggles within and between the

professions/professionals they employ or have contact with through the course of service delivery (Reitan, 1998). Such struggles can result from a variety of issues including turf (identity, recognition, privileges, etc.) and approach (philosophy, values, goals, responsibilities, service delivery methods, etc.) (Wilensky, 1964). Given that human service organizations tend to employ members of the same profession, conflicts between professions manifest themselves as interorganizational conflicts (Reitan, 1998). Thus, at least in this instance, interorganizational and interprofessional tend to be synonymous (Hall, 1986 as cited in Reitan, 1998). Although interorganizational and interprofessional relationships are often tedious, Reitan (1998) suggests that most professions understand the value of interprofessional relationships and will actively seek such relationships. Strengths of the professional perspective include recognition of the professional diversity in human service organizations and acknowledgement of the ideological power struggles among human services professions (Reitan, 1998). On the other hand, the perspective neglects the roles of semi and non-professional human services employees and the impact of organizational guidelines set by administrators, who may not be professionals (Reitan, 1998; Wilensky, 1964).

Leadership and Organizational Learning

In approaching interorganizational relations from this point of view, one would be concerned with the leadership skills and activities required for development and maintenance of interorganizational relations. While early organizational management theories and studies tended to focus on management of employees and internal dynamics/operations, recently researchers have turned their attention to the skills necessary for managing external relationships (Reitan, 1998). Such skills are often referred to as "new management skills" and include, but are not limited to, boundary spanning roles/skills (spokesperson, negotiator, and management of political and community dynamics), recognition of environmental opportunities and hazards, game-playing, joint action, network development/maintenance, relationship building, participatory planning, coordinating and sharing of tasks, collective decision making, problem solving/conflict resolution, facilitative leadership, and empowerment (Argranoff

& McGuire, 1999; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Gibaja, 2001; Mandell, 2001; McGuire, 2002; Rhodes, 1996 as cited in Reitan, 1998; Sheppard & Tuchinsky, 1996). While the focus on leadership is important to developing competent leaders, Reitan (1998) notes that it has its pitfalls, such as the tendency to attribute organizational accomplishments to the leader's efforts instead of the whole (for more information see Block, 1996; Greenleaf, 1977 & 2003). Given the likelihood that interorganizational relationships among human service organizations tend to evolve from interactions among human service professionals, Reitan (1998) questions the importance of administrative involvement in relationship building.

Sociology of Knowledge and Marxist Perspective

Although these two approaches are concerned with the relationship between knowledge and the structure of society, they disagree on the basic unit of society (Reitan, 1998). While Marxism identifies social class as the basic unit, sociology of knowledge views group as the basic unit (Reitan, 1998). Despite this difference, both approaches are relevant to interorganizational relations as evidenced by the following assertions and characteristics: 1) relationships among entities are used to obtain and maintain power (Mizruchi & Galaskiewicz, 1993 as cited in Reitan, 1998), 2) human services assist in the maintenance of power through the pacification and social control of the masses (Hasenfeld, 1992, as cited in Reitan, 1998), 3) the recognition of a program as legitimate may be motivated by irrational factors and self-serving motives (Reitan, 1998), 4) an emphasis upon the political roles of human services in the larger social system (Reitan, 1998), and 5) the relationship between the economy and human service organizations (Reitan, 1998). Interestingly, the first assertion is congruent with the literature regarding the "dark side" social capital or the use of relationships to control and restrict access to social and economic resources (Portes & Landolt, 1996; Raab & Milward, 2003; Schulman & Anderson, 1999).

Institutional Theory

Institutional theory is concerned with explaining the development of organizations and the process of socializing an organization to its domain, including structures, processes, approaches, philosophy, and competencies (Hall, 1996; Reitan, 1998). Organizations are viewed as "abstractions created by socially constructed images, rules, and classifications" (Reitan, 1998, p. 298). Organizations are also believed to be shaped by internal and external forces, not rational processes (Hall, 1996). Furthermore, institutional theory proposes that when organizations are exposed to identical conditions, they will adapt in a similar manner (Hall, 1996; Reitan, 1998). This is commonly referred to as institutional isomorphism, which occurs via coercive, mimetic, and normative isomorphism. Coercive isomorphism results from a variety of environmental forces that influence organizations, i.e., power structures, regulatory bodies, and cultural expectations (DiMaggio & Powell, 1983; Hall, 1996). Mimetic isomorphism occurs when an organization finds itself in an ambiguous or unfamiliar situation and seeks to address it via structures or methods previously employed by organizations in similar situations (DiMaggio & Powell, 1983; Hall, 1996). Normative isomorphism is a direct result of professionalization, including an increase in professional organizations and training (DiMaggio & Powell, 1983; Hall, 1996). Given the above information, the strengths of this theory lie in the attention given to the influence of internal and external forces, as well as the implications for understanding organizational culture and change. Major criticisms of this theory include 1) failure to acknowledge the impact of interests and politics upon institutional processes, 2) lack of attention to the role of organizational conflict, and 3) absence of criteria for determining what is and is not institutionalized (Hall, 1996; Reitan, 1998).

Economic Organization Theory

Economic organization theory includes two theories, transaction cost economics (TCE) and principal-agent theory, both of which are predictive in nature and focus on economic organization (Reitan, 1998). TCE focuses primarily on the organizational methods of resource acquisition and the related costs (Hall, 1996; Peterson, 1993; Reitan,

1998). While it emphasizes the management of structures that guide exchanges of physical goods, it is also applicable to service related transactions (Peterson, 1993; Reitan, 1998). The underlying assumptions of TCE include bounded rationality, asset specificity and that other organizations are opportunistic (Reitan, 1998; Sheppard & Tuchinsky, 1996). Bounded rationality recognizes that rational decisions are impacted by the personal characteristics, motivations, values, and loyalties of decision-makers, as well as the impossibility of knowing all the factors and possible outcomes of the decision (Netting, Kettner, & McMurtry, 2004). Thus, the decision-making process consists of satisficing or the identification of solutions that are satisfactory rather than ideal (Netting et al., 2004). Asset specificity is the "degree to which parties have developed assets that are of greater values to their partner than to others in the market" (Sheppard & Tuchinsky, 1996, p. 335). The strength of TCE lies in its' attention to bounded rationality, transactions, and management of organizational and environmental instability (Reitan, 1998).

Principle-agent theory differs from TCE in that its primary focus is on transactions involving services with a specific emphasis on selection, motivation, and monitoring of labor contractors (Peterson, 1993; Reitan, 1998). The key assumption of principle-agent theory is that the interests of principles and agents differ (Hill & Jones, 1992). These differences are addressed via the development of a contract that allows the principle to monitor agent activities and distributes risk among those involved (Eisenhardt, 1989; Hill & Jones, 1992). A strength of principle-agent theory is its' recognition of conflict within the various levels of government, as well as between bureaucrats and politicians (Reitan, 1998; Worsham, Eisener, & Ringquist, 1997). It also reminds us of the role of self-interest in organizations, the importance of information, the need to consider risk in decision-making, and the difficulties in assessing agent behavior (Eisenhardt, 1989; Worsham et al., 1997). Criticisms of principle-agent theory include the assumptions that relationships are dyadic instead of complex, decision-making will be based on quality information, and equilibrium is the normal state for systems (Hill & Jones, 1992; Reitan, 1998; Worhsam et al., 1997).

The relevance of economic organizational theory to human services and interorganizational relations is supported by the following: 1) interorganizational relationships are commonly centered on service transactions, 2) bounded rationality is applicable given the dynamics resulting from multiple players, and 3) interorganizational relationships often serve as a vehicle for ensuring the appropriate implementation of public policies (Reitan, 1998). An inherent weakness in the context of interorganizational relations is that decisions in human services are driven by factors other than cost and rationality (e.g., relationships, trust, equity, human rights, justice, etc.) (Reitan, 1998). Also, the underlying assumption that agents cannot be trusted to fulfill their responsibilities may serve as a barrier to interorganizational relationships (the importance of trust will be discussed in subsequent sections).

Resource Dependence or Power Dependence

Reitan (1998) notes that this theory was developed by Zald (1970) and is commonly employed in the examination of organizations and interorganizational relations. She reports that the theory consists of a descriptive model (organizational dependence upon the environment) and a prescriptive model (dependency management). Resource dependence is similar to the theory of political economy and is built around the belief that organizational decision-making is an internal process focused on goal achievement (Hall, 1996; Raak & Paulus, 2001; Reitan, 1998). Since the primary goal is survival, which is dependent upon internal and external resources, organizational decisions are influenced by environmental factors (Hall, 1996; Raak & Paulus, 2001; Reitan, 1998). It is important to note that resources include, but are not limited to money, employees, facilities, information, knowledge, technology, social capital and support, and political capital (Hall, 1996; Raak & Paulus, 2001; Reitan, 1998). Given this, organizations actively seek stability and predictability via control of environmental factors, which is most often obtained through relationships with other organizations (Raak & Paulus, 2001; Reitan, 1998). However, an organization will only seek out such relationships if it views itself as dependent upon the relationship (Raak & Paulus, 2001). From this point of view dependence is synonymous with power and is either symbiotic

(balanced) or competitive (differential) (Raak & Paulus, 2001). It should also be noted that dependence upon another organization could decrease organizational autonomy, foster goal displacement, and limit the organization's political power and activities (Hardina, 2002). The strengths of this approach are based on its acknowledgement of the dynamic nature of relationships, dependence or power, and the importance of external relationships. Proposed weaknesses of the theory include its' failure to consider the impact of goals and institutional restrictions (e.g., facilities and geographical distance) upon decision-making (Hall, 1996; Reitan, 1998).

Systems Theory

Systems theory seeks to understand the operations of systems or "complexes of elements standing in interaction" (von Bertanlanffy, 1968, p. 33) through examination of their relationships, both among components or subsystems and with the environment (Burrell & Morgan, 1979). Systems theory is based on the concept of holism, which proposes that in order to understand a system, the entire system must be the subject of inquiry, not its individual components (Whitchurch & Constantine, 1993). Systems are either closed, one that is isolated from its environment, or open, one that actively engages with its environment (Payne, 2005; Raak & Paulus, 2001; von Bertanlanffy, 1968; Whitchurch & Constantine, 1993). In fact, survival of an open system is dependent upon on its ability to exchange (import/export) energy or resources with the environment (Burrell & Morgan, 1979; Katz & Kahn, 1966; Whitchurch & Constantine, 1993). In order to maintain such exchanges, the system must be able to modify its internal and external relationships. Additional characteristics of systems theory include recognition of the interdependent nature of relationships, the importance of meeting system needs, and the presence of interdependent subsystems (Raak & Paulus, 2001).

The systems perspective of organizations emerged late in the 1950s as a result of merging concepts from structural-functionalism and general systems theory (Hassard, 1993). Structural-functionalism is predicated on the idea that social structures are similar to biological structures in that both possess the needs of survival and adaptation (Hassard, 1993). Such needs are fulfilled via organizational interdependence or interrelationships

and are the subject of organizational analysis, rather than the subsystems that comprise the relationships (Hassard, 1993). Conversely, general systems theory focuses on the processes stemming from the interrelationships and how such processes influence the subsystems (Hassard, 1993). According to Hassard (1993), the blending of these two perspectives yields a view of organizations as a

> group of phenomena that is inter-dependent in such as way that it strives to accomplish a common goal. Advanced systems contain sub-systems which operate in an independent way but again tend to be inter-dependent and oriented toward the overall goal of the wider system. In fulfilling this goal, a system interacts with and exists within a specific environment. The nature of this interaction means that a system can both influence, and be influenced by, its environment. This quality of interaction allows us to discuss the exchange of inputs and outputs, which in turn enables us to determine the system boundary. On recognizing the different forms of system boundary, we are able to talk of organizations displaying closed, partially open or open systems behaviour (p. 310).

As noted above, organizations are characterized as closed, partially open, or open systems.

Since the closed system perspective views organizations as independent or self-sufficient and is primarily concerned with increasing internal efficiency, it focuses on internal structures, tasks, processes, and formal relationships (Hassard, 1993). Given that closed systems do not emphasize the importance of environment, they do not collect data on environmental changes (Katz & Kahn, 1966). While the partially open system perspective acknowledges the impact of environment upon organizational functioning, its primary focus remains on internal organizational factors (Hassard, 1993). In fact, the attention given to external factors tends to be limited to being offered as potential explanations for the results of an organizational analysis (Hassard, 1993). An open systems perspective views the organization as engaged in a dynamic exchange or relationship that is characterized by a cyclical flow of energy or resources from the environment, into the organization, and back into the environment (Hassard, 1993; Katz

& Kahn, 1966). During this process, the organization modifies it processes and structure to adapt to changes in the environment, allowing it to maintain a steady state or dynamic equilibrium (Hassard, 1993; Katz & Kahn, 1966). Organizational analysis from an open systems perspective "should focus on the boundary exchanges of resources between the focal system and the subsystems of the environment, as organizations depend for their survival on an efficient exchange of goods and services from the environment" (Hassard, 1993, p. 33).

While systems theory is fairly popular, it is not without critics. Hassard (1993) outlines the general concerns with systems theory in the following statement,

> the generic social systems approach is denounced because its methodology is static and its ideology conservative. In emphasizing equilibrium and integration, it fails to account for change and conflict. In emphasizing harmonious relations between system parts, it overlooks the dysfunctional elements of social differentiation (p. 56).

Specific issues with systems theory's application to organizations include the tendency of functionalism to overlook the role of social conflict in facilitating social change and a limited emphasis on the organization's internal functions and processes, such as planning and decision-making (Hassard, 1993). Finally, systems theory has been criticized for minimizing the impact of environmental influence and changes upon organizational functioning (Raak & Paulus, 2001).

Symbolic Interactionism

Symbolic interactionism, a form of interactionist thought concerned with the manner in which individuals interpret their environment via actions and reactions, stemmed from the work of many individuals including C. H. Cooley, John Dewey, J. M. Baldwin, W. I. Thomas, Georg Simmel, Max Weber, George Herbert Mead, and Herbert Blumer (Blumer, 1962; Burrell & Morgan, 1979; LaRossa & Reitzes, 1993; Raak & Paulus, 2001; Rose, 1962). Although the large number of contributors limits consensus regarding theoretical premises, concepts, etc., Burrell and Morgan (1979) suggest that symbolic interactionists agree on the following description:

> In non-symbolic interaction human beings respond directly to one another's gestures or actions; in symbolic interaction they interpret each other's gestures and act on the basis of the meaning yielded by the interpretation. An unwitting response to the tone of another's voice illustrates non-symbolic interaction. Interpreting the shaking of a fist as signifying that a person is preparing to attack illustrates symbolic interaction. Mead's concern was predominately with symbolic interaction. Symbolic interaction involves *interpretation*, or ascertaining the meaning of the actions of remarks of the other person, and *definition*, or conveying indications to another person as to how he is to act. Human association consists of a process of such interpretation and definition. Through this process the participants fit their own acts to the ongoing acts of one another and guide others in doing so (Blumer, 1966, p. 537-538).

Symbolic interactionism is based on three key themes that are depicted via seven assumptions (LaRossa & Reitzes, 1993). The first theme addresses the relationship between human behavior and the meanings assigned to objects and experiences (LaRossa & Reitzes, 1993). This theme consists of the following assumptions (LaRossa & Reitzes, 1993, p. 143):

- Assumption 1- "Human beings act toward things on the basis of the meanings that the things have for them"
- Assumption 2- "Meaning arises in the process of interaction between people"
- Assumption 3- "Meanings are handled in and modified through an interpretive process used by the person in dealing with things he or she encounters"

The second theme emphasizes the role of self-concept through two assumptions (LaRossa & Reitzes, 1993, p. 144):

- Assumption 4- "Individuals are not born with a sense of self but develop self concepts through social interaction"
- Assumption 5- "Self concepts, once developed, provide an important motive for behavior"

The final theme addresses the symbolic interactionalism's view of society via two assumptions (LaRossa & Reitzes, 1993, p. 144):

- Assumption 6- "Individuals and small groups are influenced by larger cultural and societal processes"
- Assumption 7- "It is through social interaction in everyday situations that individuals work out the details of social culture"

Of particular importance is the theory's departure from the traditional sociological view of society as consisting of individuals whose behavior is a response to external forces or social factors (Blumer, 1962). Instead, it takes the stance that individuals have selves or "act by making indications to themselves" (Blumer, 1962, p. 185). In other words, behavior is a product of one's interpretation of one's situation, not a reaction to external forces. This view is applied to acting units or systems (individuals, families, groups, organizations, and communities). In terms of interorganizational relations, the importance of symbolic interactionism is that it does not "exclude the existence of phenomena such as institutions, power structures and roles," but rather concerns itself with the meanings assigned to them (Raak & Paulus, 2001, p. 211).

Sociological Systems Theory

Raak and Paulus (2001) combined social systems theory and symbolic interactionism to create the sociological systems theory of interorganizational network development. They assert that because the two theories address similar phenomena from different points of view, the combination of the two is a logical choice. They also note that the strengths of one compensate for the weaknesses of the other and vice-versa. For example, social system theory's use of knowledge addresses interactionism's lack of focus on existing structures and interactionism balances social system theory's neglect of the individual's role in shaping reality (Raak & Paulus, 2001). The authors support their decision to combine these two theories with a series of studies they conducted to develop and test the theory. The focal point of this theory is the "steering" of interactions, which is the point at which the two theories meet (Raak & Paulus, 2001). The authors describe steering interactions as "social interactions between two entities (actors) that influence each other in order to achieve a goal" (p. 216). Steering interactions involve two roles, steering actors and steered actors, which actors alternate between (Raak & Paulus, 2001).

Furthermore, actors are governed by rules that dictate acceptable and unacceptable steering actions. Interestingly steering occurs via the application of existing rules and the introduction of new rules. The role of steering in interorganizational relations will be discussed later with the concept of power.

Relevance to Interorganizational Relationships

While each of the aforementioned perspectives and theories has some degree of relevance to interorganizational relationships, systems theory and resource/power dependence theory are particularly important. The importance of systems theory lies in its acknowledgement of the following: the impact of external factors upon the internal functioning of an organization, the reality of organizational interdependence, i.e., subsystems are both independent and dependent, and that survival is dependent upon the organization's ability to adapt to environmental conditions. Resource/power dependence compliments systems theory by expanding upon the relationship between an organization's need to survive and its behaviors, such as decision-making and the use of relationships to acquire and control resources. It also offers a description of the various types of relationships and contexts in which they occur. Although systems theory has been accused of overlooking the role of change and conflict, resource/power dependence theory compensates for this, to a degree, by recognizing the impact of competitive relationships upon organizational functioning. Thus, together these theories offer a comprehensive framework for understanding and explaining the various aspects of interorganizational relationships.

Types of Interorganizational Relationships

While there are many theoretical views of interorganizational relationships, the literature is fairly consistent in its descriptions of the different types of such relationships. The majority of the literature presents interorganizational relationships in the form of a continuum based on the level of commitment, scope, independence, and resources dedicated to the relationship (Austin, 2002a; Franklin & Streeter, 1995; Golensky & Walker, 2003; Hodges et al., 2003; Lacky, Freshwater, & Rupansingha, 2002; Mandell,

2001; Mattessich, Murray-Close, & Monsey, 2001; Reitan, 1998; Walter & Petr, 2000). For instance, Franklin and Streeter (1995) propose five types of approaches to interorganizational relations: informal relations, coordination, partnerships, collaboration, and integration. Even though their version of this continuum is presented in the context of school-community relationships, it is applicable to human service relationships and was a key resource in formulating the overview of the relationship types presented in Figure 1 (see page 30).

Although it is likely that the majority of, if not all, human service organizations have at one time or another engaged in some form of interorganizational relationship, they are less likely to have engaged in collaboration or service integration. The reduced likelihood of such is directly related to the degree of commitment required of collaboration, which is exemplified by the following definition of collaboration:

> …[collaboration] goes beyond communication, cooperation, and coordination. As its Latin roots- *com* and *laborare*- indicate, it means "to work together." It is a mutually beneficial relationship between two or more parties who work together toward common goals by sharing responsibility, authority, and accountability for achieving results. Collaboration is more than simply sharing knowledge and information (communication) and more than a relationship that helps each party achieve its own goals (cooperation and coordination). The purpose of collaboration is to create a shared vision and joint strategies to address concerns that go beyond the purview of any particular party (Chrislip & Larson, 1994, p. 5).

While other definitions of collaboration (Alter & Hage, 1993; Austin, 2002a; Franklin & Streeter, 1995; Gibaja, 2001; Golensky & Walker, 2003; Hodges et al., 2003; Hosley, Gensheimer, & Yang, 2003; Lasker, Weiss, & Miler, 2001; Linden, 2003; Mandell, 2001; Mattessich et al., 2001; Mizrahi, 1999; Snavely & Tracy, 2000; Vangen & Huxham, 2003; Walter & Petr, 2000) vary to some degree, they are consistent with Chrislip and Larson's (1994) definition. As for service integration, it is simply taking collaboration a step further as evidenced by the information provided earlier and the following definition, "service integration approach calls on agencies to combine organization structures

through such procedures as sharing office space, sharing client information, sharing staff and coordinating staff assignments, and jointly applying for grants or engaging in joint budgeting" (Kagan, 1993 as cited in Snavely & Tracy, 2000, p. 147-148).

Figure 1: Continuum of Interorganizational Relationships

Continuum of Interorganizational Relationships

Degree of Commitment and Formality

Least → **Most**

Relationship Type	Description
Informal Relationships	• Relationships are loosely defined and may only exist because of a common client • Limited joint service planning communication, but friendly • Inconsistent service coordination and follow up • Limited training • Workers are the key point of contact and provide leadership functions, if there are any • Requires a minimum amount of additional funding • Limited potential for systemic change
Coordination	• Requires some commitment to develop formal relationships • Relationships are centered on the coordination of services for common clients, usually includes joint treatment planning, brokerage case management, and consistent follow up • Includes some degree of community planning, but agencies maintain separate goals, etc. • Training focuses on increasing staff abilities in regards to service coordination • Workers provide most of the leadership functions, with some involvement of administration in coordination of services • Requires an accessible network of service providers • Minimal potential for systemic change due to informal links, but increased potential for client change
Partnerships	• Implementation requires an increased degree of formal commitment • Community level planning takes place at a formal level • Training focuses on educating all members on roles, functions, expectations, etc. • Leadership functions provided by frontline staff with increased involvement from executive leadership • Requires an accessible network of service providers and additional funding to develop new services to address identified needs • Systemic change may occur in the context of reorganization to address additional services • Increased chances for systemic change and growth, especially if the efforts are successful
Collaboration	• Formal commitment is required from executive management and possibly the board of directors and similar governing bodies • Involves comprehensive planning regarding delivery and structure of joint services • Training occurs on a regular basis and is interprofessional in focus • Primary leadership function is provided by Executive management, with active participation from agency managers and personnel • May require new staff, resources, facilities, etc. to support the collaboration • Requires additional financial support to increase service delivery • Requires significant changes in the social service delivery system, but yields beneficial results including new programs and resources for clients
Service Integration	• Formal commitment extends to local, regional, and state levels • Planning occurs at the state level, but should involve local stakeholders • Interprofessional and interdisciplinary training across all levels of the network • Leadership from state political and administrative leaders with active involvement of local leaders • Requires joint initiatives, as well as redefining and redistributing resources • Additional funding is required for all partners to support restructuring activities • Structure and processes of the network are completely reformed, resulting in maximum benefit to the system via comprehensive and efficient service delivery systems

Components of Collaboration

Imagine bringing together several large human service organizations, all with different philosophies, purposes, goals, agendas, dynamics, etc., and asking them to identify and work towards a common goal that is in the best interest of their client population. If the thought itself is overwhelming, imagine the complexity of the actual process. How should one approach the development of such a network? Luckily a fair amount of attention has been given to this topic over the past twenty or so years, resulting in a number of articles, books, guides, and other forms of media identifying a variety of "keys" to successful collaboration. During this time ideas have changed, theories have evolved, and a variety of important concepts and tactics have been identified, including trust, inclusion, engagement, assessment, empowerment, strategic selection of members, stakeholder involvement, servant leadership, shared leadership, and consensus building. As for the recent literature, it tends to focus on the identification of factors that influence collaborative efforts, prescriptive guides to building successful collaboration, and management of collaborative networks. Specific topics, including trust, power, membership, structure, leadership, and barriers to collaboration will be addressed individually in the subsections to follow.

Trust

Most would agree that an essential building block of individual relationships is the mutual or reciprocal exchange of trust, the confidence in another's capacity for honesty, integrity, reliability, and accountability. The importance of individual relationships to those between larger systems is supported by Snavely and Tracy's (2000) findings that the most common form of collaboration was collaborative case management activities, which serves to develop trust among workers and eventually organizations. In the context of interorganizational networks, trust is defined as "the obligation to attend broadly to the concerns of others in the network" (Barber, 1983 as cited in Agranoff & McGuire, 1999, p. 6). Trust serves many important roles in interorganizational relationships, such as the catalyst for network formation, strengthens the network, assists in network maintenance, and reduces the need for partners to "keep an eye on one

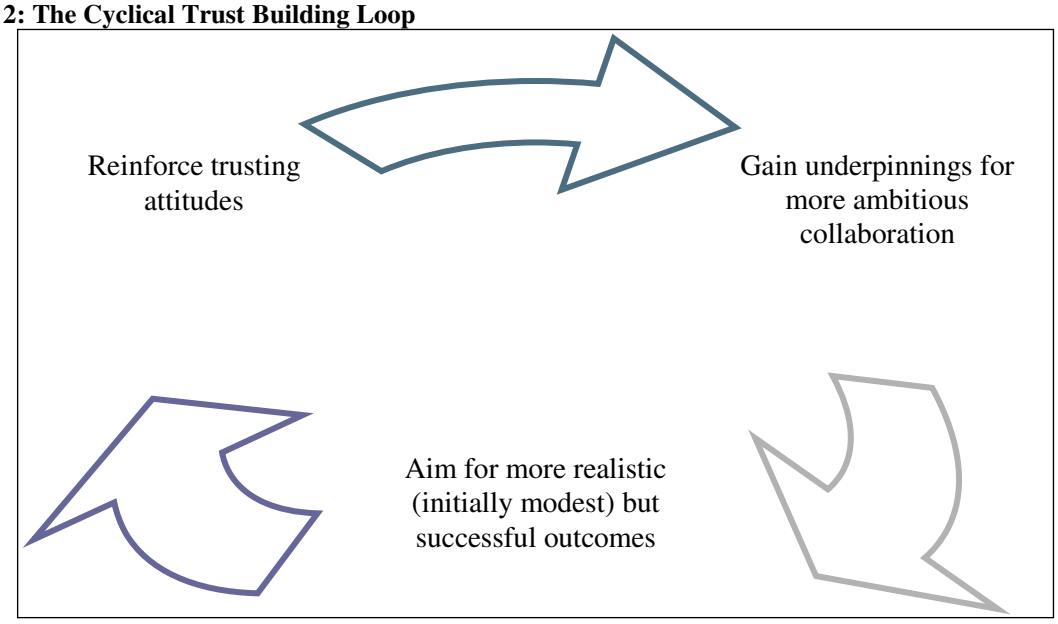
another" (Chrislip & Larson, 1994; Lackey et al., 2002; Reitan, 1998; Vangen & Huxham, 2003). Simply, trust is the "glue" that holds the relationships together. Trust appears frequently in the literature and research and is often discussed in conjunction with reciprocity, power, control, leadership, network structure or other related concepts. These pairings are reasonable, especially since they are closely related (Agranoff & McGuire, 1999; Hosley et al., 2003; Lackey et al., 2002; Vangen & Huxham, 2003). While the current studies on trust are informative, there are other important aspects that need to be addressed, such as in the context of interorganizational relationships from a management perspective (Vangen & Huxham, 2003). In addition to addressing this perspective of trust, Vangen and Huxham (2003) offer a practice oriented theory of trust building.

Vangen and Huxham (2003) began with a detailed review of the literature regarding collaboration and trust. They identified ideas, concepts, and statements with implications for practice and sorted them into the following conceptual domains: expectation forming, risk, trust, cyclical development, and trust building. From this data they developed a trust-building model centered on the premise that "trust building is a cyclical process and that with each positive outcome, trust builds on itself incrementally, over time, in a virtuous circle" (Vangen & Huxham, 2003, p. 8). However, they note that the drawback to the model is that actions resulting in success are not enough to generate trust. In other words, one must not ignore the other key factors to collaboration, such as purpose, structure, power, and leadership (Vangen & Huxham, 2003). See Figure 2 on the following page for a basic representation of the cyclical trust building loop (adopted from Vangen & Huxham, 2003, p. 12).

The second part of Vangen and Huxham's (2003) methodology involved a review of practitioner statements from their data gathered during their empirical studies of collaboration. They selected statements containing the words power, control, and trust and engaged in a process similar to the one previously described. The process yielded that "although practitioners do not provide much spontaneous elaboration on trust, the majority argues that trust is an essential ingredient for successful collaboration and

usually that they perceive a lack of trust in their own collaborative situations" (Vangen & Huxham, 2003, p. 8).

Figure 2: The Cyclical Trust Building Loop



The third part of the process included an additional literature review and examination of empirical data with the goal of identifying keys to facilitating the development of trust and specific barriers to such. This focus was prompted by their earlier literature review, which led them to conclude that

> …trust cannot be built in isolation of any other key variables and that trust building requires investment of time and careful consideration of other key issues including the management of purpose, power imbalances, credit sharing, the need for leadership while not allowing anyone to "take over" and, so on (Vangen & Huxham, 2003, p. 8).

This process resulted in the identification of the following key factors of trust building from a practitioner's perspective (Vangen & Huxham, 2003, p. 15):

- have clarity of purpose and objectives
- deal with power differences
- have leadership but do not allow anyone to take over
- allow time to build up understanding

- share workload fairly
- resolve different levels of commitment
- have equal ownership and no point scoring
- accept that partnerships evolve over time

The above factors informed the development of the cyclical trust-building process, which is the practical application of the cyclical trust-building loop. This process consists of two stages, initiating the trust-building loop and sustaining the trust-building loop. The initiation stage involves the process of forming expectations (identifying partners and agreeing on goals) and managing risk (Vangen & Huxham, 2003). Sustaining the trust building loop involves managing dynamics, managing power imbalances, and nurturing the collaborative relationships (Vangen & Huxham, 2003). Vangen and Huxham (2003) view their work and subsequent theory as important for two reasons: 1) it supports the assertion that managing trust requires one to function in situations of limited trust and to develop trust when conditions are amenable to such.

Power and Politics

Power is the ability to influence the actions of others (Denhardt, Denhardt, & Aristigueta, 2002; Netting et al., 2004; Pfeffer, 1981; Northouse, 2004) and has been characterized as the "other face of trust" (Agranoff & McGuire, 1999, p. 8). Power is "immanent in all human activity, it is the means by which all things happen and it is diffused throughout society at all levels" (Foucault, 1978 as cited in Raak & Paulus, 2001, p. 212). Human service organizations are no exception. In fact, Pfeffer (1981) believes that power and politics (the utilization of power) are the keys to understanding organizations (for politics also see Denhardt et al., 2002; Netting et al., 2004). Pfeffer (1981) proposes that power is related to organizational position and is exercised in order to meet goals, which could be those of the organization or of a subunit (department, group, individual, etc.). Furthermore, the emphasis is on obtaining the desired outcome, which may or may not be the rational choice. Thus, organizational politics consist of the exercise of power in pursuit of individual and organizational goals, which may not be congruent or rational.

To this point, power and politics have been discussed in an intraorganizational context, however, their influence expands past organizational boundaries. Wamsley and Zald (1976) expanded upon Pfeffer's idea of power and politics by noting that one must examine internal and external politics when seeking to understand an organization (as cited in Netting et al., 2004). This viewpoint was extended via the political economy model, which focused on the interaction between internal and external political (acquisition of power) and economical (acquisition of resources) activities (Netting et al., 2004). The interactions of these forces impact the organization as well as its environment, including relationships with other organizations. Furthermore, a collaboration of organizations could be viewed as a system which must interact with its environment in the same manner, yielding it susceptible to the same internal and external forces. Therefore, individual organizations as well as networks of organizations are influenced by power and politics.

While there are many other interesting aspects of power, such as types, structure, acquisition, maintenance, and balancing, the current literature on interorganizational relationships tends to focus on its application and affects upon the network. For example, as previously mentioned, sociological systems theory of interorganizational development discusses the application of power in terms of steering, which is simply the "execution of power during interactions" (Raak & Paulus, 2001, p. 217). Steering occurs through efforts that are designed to influence an actor to behave in a specific manner (Raak & Paulus, 2001). Such efforts are applied via network relationships and conveyed through verbal and non-verbal communication (Raak & Paulus, 2001). Interestingly, because a system consists of many actors and relationships, change occurs via cooperation among actors instead of at the hands of one (Raak & Paulus, 2001). Thus, all of the actors have power to some degree and are dependent upon one another for the exercise of power (Raak & Paulus, 2001).

Raak and Paulus (2001) base their theory upon empirical data from the literature and a case study of the Dutch health and social care system. One of the more interesting observations they made is as follows:

> …it was not the mere possession of formal authority that facilitated network development. Instead, the way they used authority and the meaning attached by the project participants to the project directors' actions- favourable or unfavourable for goal achievement by the participants- were considered important (p. 215).

This example clearly supports the premise of symbolic interactionism that importance lies in the meaning attached to the concept or object. Additional results from their studies with implications for application of power in human service networks include:

- Smaller differences in power tend to reduce the ability of actors to influence one another, which increases their willingness to reach consensus.
- Smaller differences in power also reduce one's ability to set and impose rules.
- Regardless of the interactions, outcomes will be more congruent with those sought by the dominant actor than those of the subordinates.
- Steering actions can only be understood in the context of their underlying meanings, goals, values, etc.
- In order for facilitators to engage in steering, they must be aware of the resources required of participants for goal achievement.

Cloke et al. (2000) offer another view of power in interorganizational networks resulting from their study of a collaborative effort to address homelessness in rural England. The partnership, charged with formulating a solution to the issues of homelessness, consisted of members from law enforcement, local government, and voluntary organizations. Other than the absence of the target population, the partnership appeared to be balanced in terms of representation and power. However, the business sector held the upper hand. Specifically, the local government relied upon the business sector for direction on major issues in an attempt to maintain their presence in the community (Cloke et al., 2000). Dependence upon the business sector led the government to ignore the opinions of the volunteer organizations, which were primarily concerned with provision of services to the target population, not punishment for vagrancy (Cloke et al., 2000). The conflicts that ensued paralyzed the partnership's

ability to move forward and resolve the issue. Cloke et al. (2000) use this case to illustrate the following aspects of power and interorganizational relations:

- Regardless of the degree of honesty in the relationship, it is susceptible to the pre-existing views of the issues and by the unequal distribution of power and resources
- Partnerships are impacted by the power of their members
- When the power distribution is unequal, "it is much more difficult to deconstruct the discursive power of 'loud voice' groups" (p. 129). Additional support for this point is offered by Jones and Little (2000).
- Lack of financial support for the partnership is an indicator of low commitment.

Despite the fair amount of attention given to trust in the literature, Agranoff and McGuire (1999) suggest the need for additional research to explore the different aspects of power, as well as its relationship to trust.

Membership and Structure

Decisions regarding who should be involved in the relationship (membership) and the conditions under which the relationship will occur (structure) are closely related to trust, reciprocity, power, and politics (Cloke et al., 2000; Lackey et al., 2002). Although Poole (2002) discusses membership in the context of communitywide collaborative efforts, his recommendations are directly applicable to interorganizational relationships. Specifically, he notes that membership should consist of representatives from the following areas: political, economic, moral, and technical. He proposes that the absence of critical representation leads to a lack of ownership or power, especially on behalf of the citizens, to hold the responsible institutions accountable for their actions or inactions. Cloke et al. (2000) offer similar advice based on their study of a rural interorganizational relationship, "only those citizens and voluntary groups with the requisite resources and skills are likely to be able to discharge the responsibilities that partnership entails" (p. 113). Furthermore, they argue against the exclusion of the client/target population, stating that doing so limits the understanding of the issue as they experience it and their

subsequent needs. Additional support for client and broad community involvement is offered by Hosley et al., (2000), Hodges et al. (2003), Jones & Little (2000), Lane & Turner (1999), Mizrahi (1999), and Walter & Petr, (2000), as well as Hudson (1993), who comments that "clients of human services are also affected by interorganizational relations because they are often served, or perhaps harassed, by several associated organizations" (as cited in Reitan, 1998, p. 287). Another pitfall of membership to be avoided is the false partnership. If members are chosen in haste, without adequate thought, or merely to fill a need for specific representation, they may not be committed to the effort (Jones & Little, 2000; Lackey et al., 2001). Additional issues regarding membership include the number of "chiefs" and the need to keep the group to a manageable size in order to avoid conflicting interests and delays in planning (Lackey et al., 2001).

In terms of structure, Mandell (2001) states that effectiveness is dependent upon a well structured network. Structure provides a means to balance power, responsibilities, tasks, and roles, which serves to foster interdependence and trust, as well as to reduce confusion and conflict (Gibaja, 2001; Lane & Turner, 1999). Lane and Turner (1999) make an additional suggestion regarding structure, early settlement of the decision-making process (i.e., How will decisions be made? Who will make them? Will certain decisions be reserved for a particular group? etc.). Mandell's (2001) case study, mentioned earlier in the context of power and politics, also has implications for structure and decision-making. Specifically, she states that "the formal rules that a foundation or government agency puts into place to guide how its resources are used creates a position of power for the organizations in the network structure" (p. 286). Unfortunately in this case study, the leadership of the organization in the position of power refused to work collaboratively with the other members, ultimately costing the partnership an opportunity for additional foundation support. While structure includes aspects of leadership, this topic will be addressed in the next section.

Leadership

The current literature relevant to the management and administration of organizations and interorganizational relationships tends to be prescriptive in nature and reflective of the shift in philosophy from closed to open systems and from management to leadership (Agranoff & McGuire, 1999; Austin, 2002b; Reitan, 1998). The literature also supports the belief that management of and within interorganizational relationships varies from the traditional management roles (Agranoff & McGuire, 1999; Austin, 2002b; McGuire, 2002). For example, Gibaja (2001) reports that the six principal themes of managing collaborative relationships are relationship building, participatory planning, coordinating and sharing of tasks, collective decision making, problem solving/conflict resolution, and facilitative leadership. Of particular interest is Gibaja's (2001) description of facilitative leadership, which consists of two dimensions: 1) ability to facilitate the development of a vision, goals, and plan based on the common purposes and goals of the members and 2) orientation to collective decision making, relationship building, and conflict resolution. Furthermore, leadership is not based on authority or position, which is conducive to avoiding a common pitfall of leadership, attributing success to the leader instead of the group (Block, 1996; Greenleaf, 1977, 2003; Reitan, 1998). Gibaja's (2001) facilitative leadership is congruent with other styles of leadership mentioned in the literature including stewardship, servant leadership, collaborative leadership, transformational leadership, and managing out (Austin, 2002b; Block, 1996; Chrislip & Larson, 1994; Crainer, 1998; Denhardt et al., 2002; Greenleaf, 1977, 2003; Northouse, 2004; Reitan, 1998).

Austin (2002b) describes management as consisting of three specific sets of functions and skills: managing down, managing up, and managing out. Managing down includes functions traditionally associated with management, such as managing employees, finances, information, and other activities related to daily operations and service delivery (Austin, 2002b). Managing up consists of activities designed to influence individuals in the upper half of the organizational hierarchy (Austin, 2002b). Finally, managing out is the process of building relationships within and outside of the organization, which requires community building skills (Austin, 2002b). Managing out is

based on two types of activities, 1) "top managers continuously network internally with their senior management group and externally with agency board members or county commissioners as well as with other community leaders and agency executives" and 2) "middle managers actively network with other middle managers inside their own agency as well as outside with colleagues in other agencies" (Austin, 2002b, p. 35). These activities can be fulfilled via leading, managing, and partnering, which are defined as follows:

- Leading is "coping with change (setting directions, aligning people, and motivating/inspiring)" (Kotter, 1990 as cited in Austin, 2002b, p. 44).
- Managing is "coping with complexity (planning and budgeting, organizing and staffing, and evaluating and problem-solving)" (Kotter, 1990 as cited in Austin, 2002b, p. 44).
- Partnering involves the "governance of human service organizations in a community" and includes a variety of collaborative and community building activities (Austin, 2002b, p. 44).

Agranoff and McGuire (1999) offer a different perspective of management and interorganizational relationships. While they agree that networks require different management skills, they examine such skills in the context of the actual management of networks, rather than management's participation in networks. One difference noted is the environment in which management takes place, networks vary from traditional organizations in that their structure tends to be flexible, allowing for "rapid adaptation to changing conditions, flexibility of adjustment, and the capacity for innovation" (Agranoff & McGuire, 1999, p. 4). Thus, functions and skills specific to the management of networks vary from those of organizational management. The functions and skills include proactive structural and operational maintenance via the addition of new members as necessary, managing/resolving issues related to turf, practices, and rules, and balancing power within the network (avoidance of hierarchical structures), confidence regarding purpose, ability to manage others (identification and utilization of strengths and resources), communication skills, ability to persuade, trust, conflict resolution, coordination, team-building, establishing/fostering a sense of common purpose, and

knowledge of professions relevant to the network (Agranoff & McGuire, 1999). These skills are consistent with those noted by Reitan (1998), including boundary spanning and the negotiation of political and community dynamics. Finally, suggested areas for additional research regarding the management of networks include the relationship between power and trust, network cohesion, network effectiveness, accountability, and the behaviors/choices of network managers (identification of choices/behaviors, reasons for such, and evaluation of them) (Agranoff & McGuire, 1999; McGuire, 2002).

Barriers to Collaboration

In addition to addressing the various elements of successful interorganizational relationships, the literature has given equal attention to the identification and discussion of common barriers to successful relationships. These barriers include disagreement regarding problem definition, lack of trust, lack of pre-existing working relationships, amount of time required for planning, demands on staff (administrative and support), turf issues, blaming other members for client difficulties, reluctance of partners to share success, breach of trust, individual instead of group focus, failure of members to fulfill obligations, difficulty in sharing organizational resources (personnel, finances, purchasing, etc.), lack of interorganizational planning, a focus on manipulating existing resources instead of acquiring additional resources, and maintaining reasonable public expectations once new resources are allocated (Anderson, 2000; Cloke et al., 2000; Jones & Little, 2000; Okamoto, 2003; Mizrahi, 1999; Springer et al., 2000; Snavely & Tracy, 2000). The literature has also dedicated a fair amount of attention to interorganizational relationships in rural areas, resulting in the identification of barriers specific to rural areas, including geographical features, geographical isolation, service accessibility, lack of public transportation, long distances between services and clients, travel time to clients, rural preference for informal helping networks, preference for self-help, suspicion of collaboration, lack of organizational resources (facilities, travel, professionals, money, etc.), difficulty in attracting and retaining professionals, lack of important organizational skills (grants, administration, and service delivery), community reluctance to acknowledge the existence of social problems, increased need for services,

geographically isolated from foundations, a limited private sector, local politics, limited leadership capacity, economic structure of the community, and limited connections outside the community (Cloke et al., 2000; Jones & Little, 2000; Lackey et al., 2002; Springer et al., 2000; Snavely & Tracy, 2000). An interesting point of view regarding rural collaboration is provided by Snavely and Tracy (2000), who describe the double-edged nature of collaboration via the following statement, "on the one hand, combining resources could be one way for rural nonprofits to overcome financial restraints. However, the competition for scarce resources in rural areas may just as well drive self-interest behavior" (p. 148-149). Given the relationship between many of these factors and the previously presented components of collaborative relationships, an overview of several studies demonstrating the impact of such barriers will be offered in lieu of addressing each barrier individually.

Practical Examples of Interorganizational Relationships

Several practical examples of interorganizational relationships taken from the literature are presented below in order to demonstrate the interrelatedness of the aforementioned components and barriers to collaboration.

Systems of Care and Texas Integrated Funding Initiative (TIFI)

Systems of care is a service delivery approach for emotionally disturbed children and their families that consists of a set of organizational change strategies intended to create and provide "access to a mixture of seamless services and supports within the context of a set of values and principles" (Hernandez & Hodges, 2003, p. 9). The systems of care service delivery approach is based on three core values, the first of which is that services are "child centered and family focused", meaning that services are individualized based on the client's needs and delivered in the context of the family (Stroul & Friedman, 1996, p. 3). The second value is that services should be delivered in the least restrictive environment, which in most cases is the community (Stroul & Friedman, 1996). The final core value is cultural competence or that services and service delivery must be consistent with and respectful of differences within the client population

(Stroul & Friedman, 1996). In addition to the core values, there are ten guiding principles (Stroul & Friedman, 1996, p. 6):

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by and individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other

characteristics, and services should be sensitive and responsive to cultural differences and special needs.

The final aspect of the systems of care approach is its client/family centered framework for service delivery that consists of eight dimensions: mental health services, social services, educational services, health services, substance abuse services, vocational services, recreational services, and operational services (juvenile probation, case management, and support services (Stroul & Friedman, 1996). Each of the dimensions includes a wide spectrum of services that are selected based on the specific needs of the client and his/her family.

The development of systems of care in Texas is supported by the Texas Integrated Funding Initiative (TIFI), which was passed by state legislators in 1999 (MHAT, 2005). The legislation required the Texas Health and Human Services Commission (THHSC) to form a consortium consisting of the Texas Education Agency (TEA), Texas Department of Family and Protective Services (TDFPS), Texas Youth Commission (TYC), Texas Juvenile Probation Commission (TJPC), Texas Department of Mental Health and Mental Retardation, and Texas Department of State Health Services (mental health and substance abuse services) (MHAT, 2005; Texas Health and Human Services Commission, 2004e). The consortium is charged with supporting the Texas Health and Human Services Commission (THHSC) in the development and implementation of systems of care in local communities (THHSC, 2004e). Financial assistance for such efforts is provided by a funding pool supported by state agencies that serve children (MHAT, 2005). Thus far, evaluations have indicated clients of TIFI programs have demonstrated emotional and behavioral improvements (MHAT, 2005). There is also evidence to suggest that TIFI programs are more cost-effective than residential treatment, a common alternative to community-based services (MHAT, 2005).

While systems of care has been recognized as a promising approach to serving children with emotional/behavioral issues (MHAT, 2005), its dependence upon collaboration makes it susceptible to the aforementioned challenges of interorganizational relationships. Specific challenges include, but are not limited to, the time and resources required to develop and maintain a system of care; tendency of leadership, staff, and

political support to change with the passage of time; and the difficulty of balancing the goals, priorities, and policies of agencies and the system of care (Hernandez & Hodges, 2003). Additional information regarding the challenges faced by systems of care is offered by Anderson, McIntyre, Rotto, and Robertson, 2002; Anderson and Mohr, 2003; Davis, 2004a; Dierker, Nargiso, Wiseman, and Hoff, 2001; Duclos, Phillips, and LeMaster, 2004; Farmer, Clark, and Marien, 2003; Hernandez and Hodges, 2003; Krauss, Wells, Gulley, and Anderson, 2001; and Stroul, 1996. The current literature also includes a variety of resources regarding the application of systems of care to service delivery for children with emotional/behavioral issues, including program evaluation and outcomes (Bickman, Noser, & Summerfelt, 1999; Cook & Kilmer, 2004; Manteuffel, Stephens, & Santiago, 2002; Tebes, Bowler, Shah, Connell, Ross, Simmons, et al, 2005), cost/benefit analysis (Foster & Conner, 2005); school-based mental health services (Purnariega & Vance, 1999), parent-school-community partnerships (Oullette, Briscoe, & Tyson, 2004), impact of managed care (Stroul, Pires, Armstrong, & Zaro, 2002), and a comparison of rural and urban clients (Dierker et al., 2004).

Texas Community Resource Coordination Groups (CRCGs)

The State of Texas mandates state human service agencies to participate in county level planning groups known as CRCGs (Community Resource Coordination Groups) that are designed to address gaps in services to children. CRCGs consists of local representatives of the following stakeholders: Department of State Health Services (DSHS), Department of Assistive and Rehabilitative Services (DARS), Department of Aging and Disability Services (DADS), Department of Family and Protective Services (DFPS), Texas Correctional Office on Offenders with Mental or Medical Impairments (TCOOMMI), Texas Department of Criminal Justice (TDCJ), Texas Department of Housing and Community Affairs (TDHCA), Texas Education Agency (TEA), Texas Juvenile Probation Commission (TJPC), Texas Youth Commission (TYC), Texas Workforce Commission (TWC), local private sector providers, and consumers, including their families and caregivers (Texas Health and Human Services Commission, 2006a, 2006b, 2006c). It should be noted that representation for DSHS includes the local MHA,

TJPC is represented by the local juvenile probation department, and TEA is represented by the local independent school district(s). The stakeholders meet on a regular basis to "staff" or discuss clients requiring involvement from multiple agencies and/or extensive resources (Texas Health and Human Services Commission, 2006a, 2006d). The stakeholders are expected to be flexible, share resources, and work collaboratively, in order to assist clients and address service delivery gaps (Texas Health and Human Services Commission, 2006a, 2006d). However, the State of Texas does not provide CRCGs with funds to carry out their mandates. Springer et al. (2000) conducted an evaluation of CRCGs, the findings of which included the following:

- "Members of urban and suburban groups are less likely to have informal contact with each other in the same way that members in small rural communities do (e.g., at the local market or church)" (p. 42). Given earlier comments regarding the importance of trust and individual relationships to interorganizational relationships this is a strength.
- Barriers to meeting the state expectations for CRCGs include "…restrained resources and limited members with the proper decision-making authority to donate services or funds (especially in rural areas), in which case a handful of select agencies end up carrying the load" (p. 46). This situation has implications for trust, power, membership, and structure.
- While they noted acceptable attendance by mandated agencies, a desire for participant variety was noted. This was accompanied by a noted lack of participation from the medical and legal community.
- Lack of involvement from mandated participants presented a greater problem in rural areas.
- There was a noticeable importance placed on developing new resources, particularly in rural areas. However, this activity was viewed as a challenge.
- "…urban respondents felt that the job they do is satisfactory, while rural respondents felt somewhat discouraged. In general, the lack of available resources seemed to cloud respondent's overall satisfaction" (p. 48).
- Need for time management and group facilitation training for leaders.

- They noted the need for community mechanisms for local citizens to engage in the identification and resolution of health and mental health issues.
- On a positive note, they reported that "boundary-spanning activities such as combining resources to meet the needs of a shared client system and working together towards a common goal have made collaboration easier for these boundary-spanning organizations" (p. 49).

Rural Non-Profits and Collaboration

Snavely and Tracy (2000) report on an empirical study of rural non-profit organizations in rural Illinois and Mississippi. Their results are compiled from 66 of the 292 organizations that were solicited for participation. The respondents completed a survey instrument designed to assess their engagement in collaborative activities, their perceptions of collaboration, perceptions of rural factors, and expansion of services. Among the results were the following:

- "Collaboration for these leaders is a means to get things done. They realize that their organization cannot operate in isolation from others. …the leaders establish personal connections with each other, building up bonds of trust, and they commit organization resources to collaboration" (p. 159).
- "It is easier for directors and staff of organizations to get to know each other and forge personal ties. Staff are likely to know individuals in other organizations….this helps make interagency interaction less formal and facilitates boundary spanning" (p. 161).
- "Collaboration is most easily accomplished at the level of information sharing, client referral, interagency problem solving (especially in respect to individual clients they share), and devising procedures for serving others' clients" (p. 161).
- "It is evident that rural nonprofit organizations are not lacking in dynamic, competent leadership" (p. 162).

Homelessness in Rural England

As previously discussed in the context of power and politics, Cloke et al. (2000) provided a case study of a collaborative effort to address homelessness in rural England. In addition to the implications for power and politics, the case yielded the following valuable information:

- They note that the group "seemed very committed to a partnership approach, but resource constraints limited their ability to provide for homelessness and other vulnerable people" (p. 129).
- They demonstrate the importance of financial commitment to the partnership, which was lacking on behalf of the local government and businesses. In fact, they note that the lack of financial support is an indicator of lack of commitment to the collaboration.
- "Within unequal partnerships such as this, it is much more difficult to deconstruct the discursive power of 'loud voice' groups" (p. 129).
- The "…case clearly suggests that partnership requires investment of human and capital resources from its participants in order to be successful" (p. 130).
- "… our conclusion is there is a danger that such an approach becomes a way of devolving responsibility and side-stepping the financial and other support necessary to deal with problems as well as a useful way of avoiding blame when things, as frequently happens where complex issues are involved, do not go according to plan" (p. 130).

A Different Point of View

While Reitan's (1998) article does not present a practical example of collaboration, she does offer some important and somewhat unique, at least in the current literature, insights regarding their practical application and implications for clients. She acknowledges the importance of interorganizational relationships to address complex issues, but appears skeptical of their benefit to clients. Her position is based on the organizational tendency toward conformity with network norms and expectations as a means of establishing legitimacy. She proposes that such norms and expectations are not

always rational or in the best interest of the client and poses the following question, "does keeping up with the Joneses really benefit the client?" (p. 304). In answering this question she arrives at the conclusion that client needs and integrity are threatened by extensive coordination, which she supports with the following beliefs:

- The blurring of organizational boundaries can decrease responsibility.
- As organizations increase their interactions regarding clients, the exchange of client information is likely to increase. She flags this as a concern and asks the question from the client's point of view, "How many agencies and agents have access to sensitive information about me?" (p. 304).
- She suggests that service integration and the resulting conformity could lead to a reduction in the variety of services, limited access to services, and reduced quality due to the absence of competition.

Additional Examples

Additional examples of the practical application of collaboration and other forms of interorganizational relations in the recent body of literature include an examination of partnerships in rural England (Jones & Little, 2003), local government cooperatives in rural Tennessee (Lackey et al., 2002), interagency collaboration benefiting children with emotional and behavioral disabilities (Anderson, 2000), collaboration among child-serving agencies (Harbert, Finnegan, & Tyler, 1997; Hodges et al., 2003; Mandell, 2001), interagency collaboration to serve gang youth (Okamoto, 2001), maintaining momentum in collaborative efforts (Lasker et al., 2001), various methods of collaboration to address homelessness (Hambrick & Rog, 2000), collaboration to develop a comprehensive service delivery system (Libby & Austin, 2002), collaboration among non-profit organizations serving low income neighborhoods (Mulroy & Shay, 1998), interagency approach to family preservation services (Campbell, 2002), and community collaborations to serve children and families (Mandell, 1999).

Current Structure of Children's Social Services in Texas

In the State of Texas, children who experience emotional/behavioral issues may receive services from one or more of the following primary providers: local juvenile probation departments, Texas Youth Commission, Department of Family and Protective Services, local Mental Health Authorities, and school districts. Services may also be provided by private or non-profit community based organizations, but the likelihood of such is lower in rural areas due to scarcity of such organizations and related resources. The following sections provide a detailed description of each primary provider, including responsibilities and limitations. The descriptions are based on: 1) a thorough review of relevant resources, including but not limited to agency annual reports, press releases, research reports, and journal articles, most of which were identified through internet search engines (google.com & msn.com) and a variety of article indexes, 2) discussions with colleagues knowledgeable in the topic areas, 3) the author's rural practice experience in community mental health, residential treatment, administration, and law enforcement, 4) information gained from local contacts, and 5) semi-structured interviews with Judy Briscoe (former employee, Texas Juvenile Probation Commission and Texas Youth Commission), Thomas Chapmond (former Executive Director, Texas Department of Family and Protective Services), Dr. King Davis (Executive Director, Hogg Foundation for Mental Health), Melanie Gantt (former Director of Public Policy, Mental Health Association of Texas), Steve Robinson (former Executive Director, Texas Youth Commission and former Chief, Travis County Juvenile Probation), Vikki Spriggs (Executive Director, Texas Juvenile Probation Commission), and Theresa Todd (Executive Director, Texas Network of Youth Services).

Juvenile Probation

Initially Texas juvenile probation departments were operated as independent entities and were not governed by a state regulatory agency. While some of the departments received funding through the Texas Youth Commission (TYC), overall there was limited state financial assistance for probation departments. This changed in 1981 when the Texas Legislature enacted Chapter 141 of the Texas Human Resources Code,

creating a state agency to regulate juvenile probation services (Texas Juvenile Probation Commission, 2005). Specifically, the legislation created the Texas Juvenile Probation Commission (TJPC), an agency supervised by the Texas Health and Human Services Commission, governed by a nine-member Board of Directors appointed by the Governor, and staffed by professionals with knowledge and experience in juvenile justice services (TJPC, 2005). The legislation identified the following organizational purposes: 1) extend juvenile probation services to the entire state, 2) increase the effectiveness of such services, 3) provide financial support to local juvenile boards in an effort to increase alternatives to commitment to TYC, 4) develop uniform standards for the provision of juvenile probation services, 5) facilitate communication between local and state juvenile justice agencies, and 6) encourage prevention and early intervention programs for juveniles (TJPC, 2005). According to TJPC (2005) these purposes are carried out via a variety of functions and activities including:

- Serving as the fiscal agent for state funds dedicated to assisting with the operation of local juvenile services
- Facilitating strategic planning and policy development in order to meet the needs of the juvenile justice system
- Regulation of local juvenile probation services, including community-based services and detention
- Provision of affordable training and continuing education to juvenile justice personnel
- Certification of juvenile probation and detention officers
- Provision of legal and technical assistance to local departments and professionals
- Development of collaborative efforts with other state agencies that provide services to children
- Assisting local agencies in the recovery of federal funds available through the Title IV-E Federal Foster Care Reimbursement Program
- Collection and management of information regarding service delivery via the CASEWORKER software application

- Publication and distribution of various materials, such as reports, manuals, and reference materials
- Education of elected officials, professionals and the public about juvenile justice issues
- Funding innovative prevention and early intervention initiatives for children
- Annual collection and dissemination of information regarding juvenile crime and the juvenile justice system

There appears to be a general consensus among those involved with children's services that juvenile probation services are currently in better shape than in the past, which is attributed to state regulations and clearly outlined guidelines for delivery of services.

While TJPC is responsible for monitoring local probation services for compliance with regulations, the actual provision of juvenile probation services is the responsibility of the local agencies. Entities with primary responsibility for providing services are the juvenile courts, county juvenile board, and county juvenile probation department. The county juvenile board consists of all the county court and district court judges in the county and is mandated by Texas statutes to govern local juvenile justice services (National Center for Juvenile Justice, 2006; TJPC, 2005). The juvenile board's specific activities include hiring the chief juvenile probation officer, approving decisions regarding budget and policies, and designating judges and courts that will hear juvenile cases (National Center for Juvenile Justice, 2006; TJPC, 2005). Currently there are 168 juvenile probation departments, each of which serves as an entrance to the juvenile justice system (National Center for Juvenile Justice, 2006; TJPC, 2005).

In order to be referred to the juvenile justice system, the child must be between the ages of 10 and 17 and must have engaged in conduct indicating a need for supervision (CINS) or delinquent conduct (TJPC, 2005). CINS includes conduct, not including traffic offenses, that is in violation of 1) penal laws and ordinances that are only punishable by fine; 2) truancy; 3) runaway; 4) abuse of inhalants; 5) violation of a school's written code of conduct that carries a penalty of expulsion; or 6) violation of court order for a child who has been declared at risk (TJPC, 2005). Delinquent conduct includes 1) a violation of the Texas or United States Penal Code that carries a punishment

of placement in a correctional facility (Class B & A misdemeanors and all felonies); 2) violation of a juvenile court order, other than one regarding fineable only offenses, runaway, or truancy; 3) violation of a municipal or justice of the peace court order that constitutes contempt of court; and 4) third or subsequent offense of DUI (driving under the influence of alcohol) by a minor (TJPC, 2005). Local juvenile probation departments address 97% of the juveniles who commit crimes; the remaining 3% are referred to TYC (TJPC, 2005). However, the percentage of offenders supervised by local juvenile probation departments will most likely increase due to recently enacted legislation that limits TYC commitments to juveniles who are adjudicated for a felony offense.

Primary responsibility for funding county juvenile services lies with the county commissioner's court, which allocates approximately 66% of the funding. Additional support is provided by state funds through TJPC (approximately 25%) and through various other sources, including federal funds. Since county budgets are supported by property taxes, counties with a larger tax base tend to provide more comprehensive and intensive community-based juvenile services. In fact, some counties are able to operate specialized "in-house" units to address a variety of issues, including sex offender treatment, mental health services, and substance abuse treatment. Such services are helpful in diverting children from TYC to the community and are usually found in larger urban counties such as Bexar, Dallas, Fort Bend, Harris, Tarrant, and Travis. Counties that are not able to provide more than basic probation services are forced to rely on local providers and resources to serve their clients. In rural counties, where such resources are often scarce and over-utilized, clients are at greater risk of referral to TYC, especially those with difficult or severe issues. It should also be noted that some rural counties do have a tax base capable of supporting specialized services, but the provision of such is not considered a priority.

As previously noted, the popular perception is that overall juvenile justice services in Texas have improved over the past 30 or so years. However, the current system is not without its challenges. For example, the emphasis on local governance of probation services makes the departments susceptible to formal and informal local and county politics, especially in areas where local power is held by a small number of groups

or individuals. Over the years legislation that would combine TYC and juvenile probation has been introduced and defeated, most likely because it would greatly reduce the power, control, and discretion of local authorities, elected officials, and judges. Also, as noted above, the funding structure is often inadequate for poorer counties. This, coupled with a depressed economy and across the board cuts in state children's services, has negatively impacted the ability of communities to treat juveniles at home and resulted in an increase in the number of out-of-home placements in residential treatment centers (RTC) and TYC. In fact, the lack of community-based supports for children, especially prevention and early intervention programs, has contributed to an increase in referrals to juvenile probation.

Texas Youth Commission

The Texas Youth Commission (TYC) is the institutional division of Texas' juvenile justice system. TYC evolved from the Texas Youth Development Council, which was created in 1949 as a result of the Gilmer Aiken Act (TYC, 2003a) and charged with assisting communities in developing youth services and oversight of the state's training schools for juveniles (TYC, 2003a). In 1957 the Texas Youth Development Council became the Texas Youth Council, bringing additional responsibilities, including administration of residential services for dependent and neglected children (TYC, 2003a). Parole services were added in 1961, with the goal of extending the continuity of care to juveniles released to the community (TYC, 2003a). While the late 1960s and 1970s brought an increase in institutional facilities, the Texas Youth Council increased its focus on community-based services for juveniles, as evidenced by an increase in community-based programs, higher utilization rates for foster care, and subsidies for local juvenile probation departments (TYC, 2003a).

In addition to the shift from institutionalization to community-based services, this time period brought three landmark cases, Kent v. U.S. (1966), In Re Gault (1967), and Morales v. Turman (1971), each of which greatly impacted the juvenile justice system. Kent v. U.S. and In Re Gault eliminated many of the informal practices of the juvenile court system and mandated the extension of the right to due process to juveniles (TYC,

2003a). Morales v. Turman, a Texas Appellate Court case, directly affected the delivery of institutional services by establishing national standards for the protection and treatment of individuals in the juvenile justice system (Bazelon, n.d.; TYC, 2003a). According to TYC (2003a), the changes in Texas resulting from Morales v. Turman included, but are not limited to:

- Established the CINS classification, consisting of status and fineable only offenses, and prohibited juveniles from being committed to TYC for CINS offenses
- Extended the right to due process in juvenile court and TYC administrative proceedings
- Prohibited the use of corporal punishment and other forms of punishment deemed to be inhumane
- Removed make-work and extended isolation from the treatment regimen
- Created a system to investigate grievances and mistreatment
- Established standards for youth-to-staff ratios, as well as minimum qualifications and training requirements for staff
- The development of treatment programs that were individualized, specialized and community-based.
- Development of halfway house programs
- Youth placed in an institution due to dependence or neglect were transferred to foster care
- TYC offered subsidies to local probation departments in an attempt to reduce commitments by increasing community-based services

In 1983, the Texas Youth Council's name was changed to the Texas Youth Commission (TJPC, 2005). TYC is governed by a six-person board appointed by the Governor with consent from the Senate (TJPC, 2005). The board is responsible for employing the Executive Director, who oversees the agency, including approximately 4,900 employees, fifteen secure institutions, nine residential programs, a variety of community-based programs and services, and contracts with 30 or so community-based service providers (TJPC, 2005; TYC, 2004). Currently, TYC focuses on treating violent

and chronic juvenile offenders through a variety of specialized treatment programs, which has included the resocialization program, capital offender program, sex offender treatment, and chemical dependency treatment (TJPC, 2005; TYC, 2004). Furthermore, state statutes have been amended to allow for the commitment and treatment of individuals with issues related to mental health or mental retardation, resulting in treatment programs and facilities for seriously emotionally disturbed youth. Originally TYC was mandated to return such individuals to the sentencing court for diversion to other services. In addition to institutional based programs, TYC offers community-based placements, parole services, and community-based services to assist juveniles in the transition from institutionalization to community life (TJPC, 2005; TYC, 2003c).

Prior to 2007, TYC served juveniles who are committed by a judge as a result of an offense committed between the ages of 10 and 17. The majority of commitments to TYC were the result of a felony offense and 80% of the juveniles referred to TYC were placed in a secure facility with the remaining 20% being placed in contract facilities (TYC, 2004). Upon commitment juveniles were assigned a minimum length of time that they had to serve before becoming eligible for parole. The minimum length of time was based upon the severity of the crime committed. Since parole was rewarded based upon progress in the Resocialization program, juveniles could be held longer than the minimum length of stay, and, in some cases, until they were 21 years of age (TYC, 2003b, 2003c, 2004). Juveniles could also be committed on a determinate sentence, allowing for up to a 40-year sentence and a court transfer to the Institutional Division of the Texas Department of Criminal Justice (TYC, 2003b, 2004). Offenses eligible for determinant sentencing included murder and attempted murder; capital murder and attempted capital murder; manslaughter and intoxicated manslaughter; aggravated kidnapping and attempted aggravated kidnapping; aggravated sexual assault, sexual assault, and attempted sexual assault; aggravated assault; aggravated robbery attempted aggravated robbery, and attempted aggravated robbery; felony injury to a child, elderly, or disabled person; felony deadly conduct; aggravated or first-degree controlled substance felony; second-degree felony indecency with a child; criminal solicitation of a minor; first degree felony arson; and habitual felony conduct (3 consecutive adjudications

for a felony) (TYC, 2003d). Once a juvenile has completed his/her minimum length of stay and demonstrated an appropriate amount of progress in the Resocialization program, he/she could be transferred to a less restrictive program and would eventually be released to the community under the supervision of a parole officer (TYC, 2003c). Once the juvenile had completed the conditions of parole or reached his/her 21st birthday, he/she was released from TYC's supervision. However, a violation of the law or conditions of parole could result in a transfer from a less restrictive setting to a secure facility (TYC, 2003c).

Until recently the overall perception of TYC was that it effectively served the State's serious and chronic juvenile offenders. This view quickly changed in February of 2007 when it became national news that "allegations of sexual abuse by two administrators at the West Texas State School had been investigated but never prosecuted" (Ward, 2007). Subsequent investigations not only suggested that TYC's administration had not taken appropriate action to address the allegations, but also uncovered additional allegations of "youth beatings, lax medical care, shady business dealings, sloppy schooling, and a culture of retaliation against whistleblowers" (Swanson & Jones, 2007). By March 2007, TYC's executive director and board of directors had been removed and Governor Perry had placed the agency under conservatorship (Springer & Colleagues, 2007; Ward, 2007). Subsequent actions include, but are not limited, to the following:

- The formation of a Blue Ribbon Task Force, which generated a comprehensive plan for revamping Texas' Juvenile Justice System, including probation, incarceration, and parole (Springer & Colleagues, 2007). Unfortunately, TYC's previous administration rejected the report (Swanson & Jones, 2007).
- The following legislation was enacted:
    - Texas HB 914- This bill established an Office of Inspector General (OIG), which is charged with investigating fraud and other crimes committed at TYC facilities or facilities under contract with TYC (TYC, 2007e).

- Texas SB 103- This bill resulted in a number of changes including limiting TYC commitments to juveniles who are adjudicated for a felony offense, mandating that juveniles be released by their 19th birthday, and creating the Special Prosecution Unit (SPU) (TYC, 2007a, 2007b, 2007d). The purpose of the SPU is to assist with the prosecution of cases arising from criminal offenses committed within TYC (TYC, 2007d).

- A decision was made to close two TYC facilities, one in Marlin and one in San Saba (TYC, 2007d).
- TYC decided to abandon its Resocialization treatment program effective September 1, 2007 and replace it with an evidence-based treatment program (TYC, 2007d). See Nedelkoff (2008) for an overview of the treatment program.
- In December 2007 Richard Nedelkoff was appointed as TYC's Conservator. Since then he has embraced the Blue Ribbon Task Force's recommendations and published a comprehensive framework to guide TYC's reform efforts (Nedelkoff, 2008). The framework focuses on five specific priorities, which appear to address the issues that contributed the agency's current predicament.

Despite these changes, TYC continues to experience problems regarding allegations of abuse, understaffing, controversial use of pepper spray, and inadequate health care (Swanson & Jones, 2007; Ward, 2007). In fact, some experts question whether or not the agency is truly capable of resolving its issues (Swanson & Jones, 2007; Ward, 2007).

Child Protective Services

Prior to January 2004 Child Protective Services (CPS) was located in the Texas Department of Protective and Regulatory Services (TDPRS). As a result of an attempt to improve the delivery of social services and reduce financial costs by streamlining organizational structures through Texas HB 2292, TDPRS was renamed the Department of Family and Protective Services (DFPS) and placed under the auspices of a newly created umbrella organization, the Health and Human Service Commission (HHSC). HHSC is responsible for the direct provision of services previously provided by the

Texas Department of Human Services (i.e., TANF, Medicaid, CHIP, etc.) and the administration of Department of Aging and Disability Services (DADS), Department of State Health Services (DSHS), Department of Family and Protective Services (DFPS), and Department of Assistive and Rehabilitative Services (DARS), all of which were created by the consolidation of ten state social service agencies. While administrative and programmatic structures of most services were changed by HB 2292, DFPS closely resembles its predecessor, TDPRS.

DFPS is headed by a Commissioner who is appointed by the Executive Commissioner of HHSC and is advised by the State Health Services Council, a non-rulemaking agency council consisting of nine members who are appointed by the Governor. The department is charged with the provision of child and adult protective services, which are implemented via the following programs: Child Protective Services (investigations, adoption, foster care, and child abuse prevention programs), Child Care Licensing, Prevention and Early Intervention, and Adult Protective Services. Child Protective Services (CPS) is mandated to protect children (up to 17 years of age) from abuse and neglect via prevention programs, early intervention programs, and investigation of abuse and neglect reports made to the department. If an investigation substantiates a report of child abuse or neglect, CPS is responsible for providing services to alleviate the abusive or neglectful behaviors. Although the preference is for allowing the child to remain in the home while supportive services are provided (i.e., parenting skills, social skills, referral to appropriate community resources, etc.), the child may be placed in foster care services (i.e., foster homes, residential treatment center, or another state facility) until the home environment is safe. In cases where the child cannot return to the home, he/she may be permanently placed with relatives, a foster care facility, or adopted.

As previously mentioned, the intent of HB 2292 was to alleviate service delivery issues by streamlining the administrative structure of state social service agencies. While there is evidence to support the need for such actions, some suggest that CPS has never had an adequate administrative structure, in which case the restructuring may have exacerbated the situation. Others suggest that administrative structure is not the only

factor contributing to DFPS's long standing problems. For example, McCown and Castro (2004a) assert that the source of the problem is not poor management or policies, but rather that CPS's initial funding base was low and has not grown in proportion to the service population. Not only has the budget remained fairly static, but due to a shortfall in the state's general revenue DFPS was subjected to approximately 16% in budget cuts during the 78th Legislative Session (2003). These cuts brought reductions in administrative and support staff, higher caseloads, less frequent inspections of child-care facilities, and a 24% budget cut for prevention and early intervention programs (TDFPS, 2003). Furthermore, DFPS was subjected to an additional 5% budget cut in 2004. It appears that the projected savings resulting from the streamlining of services has not been reinvested in the agency.

Despite the evidence to support the role of budget constraints in DFPS's current situation, the blame continues to focus on administrative issues. Such a viewpoint has been perpetuated by the recent highly publicized incidents of negligence on behalf of DFPS. In fact, several of these incidents have resulted in the preventable death of a child (THHSC, 2004a, 2004b, 2004c, 2004d). There appears to be reluctance to consider the role of a more likely culprit, inadequate financial support. The end result being an unhealthy organizational culture characterized by high employee turnover, high case loads (a reasonable caseload is 12, but the typical load is 61), poor investigative response rates, poor quality services, and an overall inability to effectively protect our children.

The aforementioned incidents have also fueled cries from politicians and the general public that DFPS should not serve the roles of both regulatory body and service provider. Many believe that the agency should not be allowed to regulate itself and that service provision should be outsourced to private contractors. Outsourcing service provision has some benefits, such as lower administrative costs, avoidance of the tendency toward lax self-regulation, and the potential to foster community and stakeholder involvement. On the other hand, poor implementation could be disastrous, especially if the resources are not adequate enough to develop and sustain the services. For instance, there is a current trend of the state delegating unfunded mandates to the

local communities, many of which, especially rural areas, do not possess the governance, administrative structure, tax base, and/or economic base to sustain such initiatives.

Mental Health Services

Texas began funding state mental health services in 1857 when it appropriated funds for the construction of the State Lunatic Asylum in Austin, which opened in 1861 and was later renamed Austin State Hospital (MHAT, 2005). While the state added six mental health hospitals to the system over a 70 year time period, a pattern of underfunding and overcrowding remained (MHAT, 2005). The Federal Mental Health Center Construction Act of 1963 brought some relief to the overcrowded state hospital system. Specifically, it resulted in House Bill 3 of the 59th Texas Legislature and the subsequent creation of the Texas Department of Mental Health and Mental Retardation (TDMHMR). The department consisted of a nine-member board of directors appointed by the Governor, an executive director, and professional staff. The department was charged with overseeing state psychiatric hospitals, schools, and human development centers. The department was also given the authority to appoint a local mental health authority to plan, develop, and coordinate mental health services in a designated service area (TDMHMR, 1996). The local mental health authority was also responsible for ensuring that services were provided to the priority population as defined by the state (TDMHMR, 1996). Such services included 1) 24-hour crisis intervention services, 2) crisis intervention through a residential facility or hospitalization, 3) assessments, evaluation, diagnosis and treatment by an interdisciplinary team, 4) family support services and respite care, 5) case management services, 6) medication related services, 7) rehabilitation programs (social skills, vocational training and living skills), and 8) aftercare services to clients discharged from a state facility (including TYC).

On September 1, 2004, TDMHMR ceased to exist and mental health services were relocated to the Department of State Health Services (DSHS), a new department created by Texas House Bill 2292 of the 78th Legislature (TDMHMR, 2004). DSHS is also responsible for overseeing alcohol and substance abuse prevention and treatment programs. The structure of DSHS is similar to that of DFPS in that it falls under the

auspices of the HHSC, is supervised by a director who is appointed by the HHSC commissioner, and is advised by a non-rulemaking agency council consisting of nine members who are appointed by the Governor. DSHS provides mental health services via eight state hospitals (Austin, Big Spring, Kerrville, North Texas- Vernon Campus, North Texas- Wichita Falls Campus, Rusk, San Antonio, and Terrell), three community hospitals (Galveston, Houston, and Lubbock), two state mental health service centers (Rio Grande and El Paso), one residential treatment center (Waco Center for Youth), and contracts with forty-one local mental health authorities (MHAT, 2005).

There are currently two state hospitals (Austin and Terrell) that serve children ages 3 to 17 whose mental health issues pose an immediate danger to themselves or someone else. San Antonio State Hospital offers services to adolescents ages 12-18 and North Texas State Hospital Vernon Campus provides forensic psychiatric services to children and adolescents. While inpatient psychiatric services are available, they are often difficult to access due to funding cuts, high censuses/limited bed space, and the lack of private facilities. Furthermore, many community providers are finding that hospital stays are shorter and children are turned away from state hospitals because they are "too sick to treat." If the provider with the most intensive services and supervision is unable to intervene, then where does one turn? Community providers also report that local MHAs, the gatekeepers to the state hospital system, are often reluctant to assess children presenting with suicidal ideation, a duty mandated by Texas statutes. Hopkins and Logan (2006) offer the following description of Texas' mental health crisis services:

> The decline in beds has corresponded with an overall reduced length of stay which is in part driven by federal and state financing strategies that include disincentives and penalties related to inpatient bed use. The lack of a quickly responsive system with appropriate range of crisis services has contributed to the increased incarceration of mentally ill individuals in jail. Just as emergency medical services (EMS) responds to medical crises for all individuals in a community, all Texans rely on hospital emergency rooms or the local mental health authority to respond to mental health crises (p. 5).

Not surprisingly, there is a growing belief that mental health services in Texas are regressing and may eventually violate clients' constitutional right to treatment. For the sake of clarity, the right to treatment is supported by legal arguments grounded on due process and cruel and unusual punishment, which stem from Donaldson v. O'Connor (1974) and Wyatt v. Stickney (1972) (Corcoran, 1998). One must also be mindful of the difference between treatment and *effective* treatment or treatment that will improve or cure a client's condition (Corcoran, 1998). Simply stated, there is legal obligation to provide services, but the provider does not have to demonstrate that such services are effective (Corcoran, 1998).

In addition to the aforementioned barriers, geographical distance further limits the ability of rural areas to access state inpatient facilities (Hopkins &Logan, 2006). Longer distances result in higher costs (man hours, gas, vehicle maintenance, etc.) for local law enforcement agencies, which are often responsible for transporting clients to the inpatient facility. For example, the mental health commitment process could easily occupy an officer for 8 to 16 hours before he/she is even cleared to leave the community and travel to the facility could take between 4 and 12 hours, depending on the location of the facility. If one takes into account the time spent at the facility waiting for the client to be admitted and the return trip, an officer(s) could easily spend between 16 and 48 hours for one mental health commitment. Also, consider that some situations will require two officers for the transport. Bexar County (San Antonio) reported spending $400,000 annually in overtime for law enforcement officers assigned to supervise offenders sent to the emergency room for mental health evaluations (MHAT, 2005). Thus, mental health commitments pose a significant challenge for many law enforcement agencies, especially those in rural areas with limited resources. Is it any wonder that law enforcement agencies are often reluctant to become involved in mental health commitments?

Community-based mental health services are provided via contracts between DSHS and local MHAs, which are responsible for providing direct services and overseeing contracted services. The local MHAs must provide the following services: 24-hour mental health crisis hotline, screenings and assessment, case and service coordination, treatment planning, skills training, respite services, family training,

medication-related services, intensive crisis residential (short-term psychiatric stabilization services), and inpatient psychiatric services (MHAT, 2005; TDSHS, 2004a). DSHS also encourages the provision of the following optional services: wraparound planning, counseling, family skills training, school-based services, rehabilitative day treatment, acute day treatment, flexible community supports (non-clinical/non-professional community resources), in-home crisis intervention, and therapeutic foster care (TDSHS, 2004a). These services are funded by the State of Texas through DSHS for the "priority population," which is defined as:

> …children and adolescents ages 3 through 17 years with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who: 1) have a serious functional impairment (GAF of 50 or less currently or in the past year); or 2) are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or 3) are enrolled in a school system's special education program because of a serious emotional disturbance (TDSHS, 2005).

Based on the above definition, children who are solely diagnosed with autism or another pervasive developmental disorder, mental retardation, or substance abuse are not considered a member of the priority population (TDSHS, 2005). While local mental health authorities may provide services to those who do not meet the criteria for the priority population, they cannot finance such services with funds provided by DSHS (TDSHS, 2005). Usually such services are funded via CHIP (Children's Health Insurance Plan), Medicaid, private insurance, private funds, and grants.

In addition to relocating state mental health services to DSHS, HB 2292 changed the mental health benefit package for children and adults. Specifically, it mandated the implementation of a resiliency and disease management model (RDM) by the 2005 fiscal year. The model is based on the delivery of services via a prescribed protocol and is intended to assist the department in further defining eligibility criteria, services to be provided, methods of service utilization management, service costs, and service outcomes (TDSHS, 2004b). The strength of this approach lies in its employment of specific protocols and evidence-based interventions. However, it is dependent upon accurate diagnosis, assessment, treatment and evaluation, as well as sufficient financial support

(MHAT, 2005). There are also concerns about the model's dependence upon bachelor level providers for the delivery of clinical interventions that have historically been provided by licensed master level mental health service providers.

Another significant change was to the CHIP benefit package, resulting in the removal of vision, dental and mental health benefits. Thus, children with CHIP whose income is too high to qualify for Medicaid and who do not have access to private insurance are left to pay out-of-pocket for mental health services. On a positive note, HB 2292 did not narrow the priority population for children, as it did for adults. There is a common belief that the legislature is not interested in changing children's mental health services to mirror those for adults, which are limited. In fact, some are hopeful that the state legislators will reconsider the current direction of adult mental health services and increase funding for mental health services. However, others remain skeptical, noting the steady decline of mental health services over time and the lack of emphasis on community-based prevention and intervention services as tools for reducing the prevalence of mental health issues and over-utilization of inpatient services.

Primary and Secondary Educational Institutions

School districts are responsible for providing an education to all of the students who reside within their service delivery boundaries, including students who require additional support and resources to learn. The needs of these "special" students are met through special education services that are designed to address a variety of issues, including mental retardation, mental health, auditory impairments, visual impairments, speech impairments, and other health issues that interfere with academic performance. Students who present with one or more of the aforementioned issues are referred to the special education department by their parent(s), teacher(s), or other school personnel. Once the special education department receives a referral, they conduct an in-depth evaluation to determine the extent and nature of the issue(s). After this is completed, an Admissions, Review, and Dismissal (ARD) hearing is held. If the members of the ARD decide the child is eligible for services, they will develop an Individual Education Program (IEP) to address the specific issues. Once an IEP is implemented, it is

monitored and modified through ARD meetings. The interventions outlined in the IEP can be provided in various situations, such as the home, a psychiatric hospital, the regular school campuses, and on special campuses.

Of specific concern is the role of primary and secondary schools in the delivery of services to children with emotional and behavioral issues. Schools are mandated to provide services to children who are identified as Emotionally Disturbed (ED), a label that is assigned by the school when it is determined that a child's emotional or behavioral issues impair his/her ability to succeed academically. Once a student is identified, the school is required to deliver educational services to the student that are consistent with his or her needs. Such services are to be provided in the least restrictive environment and may include any number of classroom modifications and services, including adaptive behavior programs (for children who are identified as emotionally disturbed), self-contained classrooms, resource programs (life skills), speech therapy, and mental health counseling.

During the 2003-2004 academic year, 509,401 students or 12 percent of the children enrolled in Texas public schools were special education students (MHAT, 2005). Of those special education students, 36,444 students or 7.5 percent were receiving special education services primarily for emotional disturbance (MHAT, 2005). The 2004-2005 academic year was consistent with the 2003-2004 academic year (Texas Education Agency, 2005). Interestingly, a study of mental health issues in Texas' juvenile justice system revealed that 10% of the 1,009 juveniles surveyed were special education students (Schwank et al., 2003). Moreover, 40% of the youth committed to TYC during the 2006 fiscal year met the criteria for special educational services (TYC, 2007). It is important to mention that ED students tend to be under-identified, which is partly due to TEA's practice of only tracking students by primary diagnosis (MHAT, 2005). Thus, those who have emotional disturbance as a secondary diagnosis are not represented in TEA's figures for the prevalence of emotional disturbance among students (MHAT, 2005). Other barriers to identifying and intervening with ED students include a lack of resources and collaboration with local providers of children's services.

While special education laws mandate the provision of appropriate services in the least restrictive environment, emotionally disturbed students often find themselves "warehoused" in programs for students with delinquent conduct, such as AEPs (Alternative Education Programs). In Texas, special education students, including those identified as emotionally disturbed, are overrepresented in disciplinary placement programs (Hogg Foundation for Mental Health, 2006). Specifically, during the 2003-2004 academic year 23.4 percent of the students placed in disciplinary alternative education programs (DAEP) and 25.8 percent of the students placed in juvenile justice alternative education programs (JJAEP) were special education students (Hogg Foundation for Mental Health, 2006). A DAEP program provides an alternative educational environment for students who have been adjudicated or who have violated the school's student code of conduct (Hogg Foundation for Mental Health, 2006). Students who are expelled from school due to adjudication for a serious offense under the Texas Education Code or present persistent behavior problems in DAEP are placed in a JJAEP (Hogg Foundation for Mental Health, 2006). Although emotionally disturbed students may engage in behavior that would warrant placement in a DAEP or JJAEP, federal law requires that the following stipulations are met prior to changes in placement:

1. The child's IEP and placement were appropriate
2. The school provided the special education services, supplementary aids and services, and behavior intervention strategies consistent with the child's IEP and placement
3. The child's disability did not impair his or her ability to understand the impact and consequences of the undesirable behavior
4. The child's disability did not impair his or her ability to control the undesirable behavior (Hogg Foundation for Mental Health, 2006).

It is also important to note that for the 2003-2004 academic year 24.1 percent of suspended students and 20.2 percent of students placed in ISS (in-school suspension) were special education students (Hogg Foundation for Mental Health, 2006).

Challenges with the Current System

To this point it has been established that the structure of children's social services in Texas contributes to the challenges faced in delivering adequate services to children who present with emotional/behavioral issues. However, structure is not the only factor. Despite the fact that social services for Texans, especially children, have been traditionally under-funded, they are consistently subjected to damaging budget reductions. Such cuts have directly targeted front end (prevention and early intervention) and back end (supportive and aftercare programs) services, leaving the middle (interventions) to bare the burden. In other words, the emphasis is clearly on intervention with limited regard for the importance of prevention and aftercare services. It also important to note that funding for interventions tends to focus on the most intensive services and cases, leaving many clients without assistance. Several examples of detrimental budget cuts and other funding related issues follow:

- "In fiscal 2001, Texas spent $38.46 per client on mental health services, placing the state among the eight comparison states and 49th among in the nation. Texas' per capita spending was only 44 percent of the national average" (MHAT, 2005, p. 4-18).
- "After adjusting for inflation, Texas spent almost 15% less on mental health in fiscal 2002 than it did in 1981. While many states lost ground in a similar fashion, Texas' inflation-adjusted losses were higher than the national average" (MHAT, 2005, p. 4-18).
- In 2001, approximately $6 million was cut from the children's mental health budget because benefits were added to the budget. Subsequently, in 2003, HB 2292 removed mental health benefits from CHIP (Children's Health Insurance Plan) and there was a 5% cut across the board, followed by an additional 7½% major emergency cut. Such cuts are blamed for the mental health system's movement to a cost benefit model, focusing on providing more services to fewer people.
- In 2003, HB 2292 brought approximately 25% in cuts to the STAR programs (Service To At-Risk Youth), resulting in the loss of a variety of services and

significant cuts to those that remained. In fact, currently the STAR program is facing an additional 25% cut ($9.4 million over the next biennium) (Greater San Marcos Youth Council, 2005). This is especially damaging given that the purpose of STAR is to provide services to at-risk youth who are not eligible for juvenile probation and child protective services.

- HB 2292 placed the Texas Council on Alcohol and Drug Abuse (TCADA) under the Department of State Health Services, resulting in the loss of match funding for federal dollars and subsequent programmatic cuts.
- Recently DFPS's level of care system (determines daily reimbursement rates for placement) was collapsed from 6 to 4 levels. The change reduced the amount of funds juvenile probation departments could recover for placement, subsequently increasing the burden on local funding sources for out-of-home placements.
- Since TYC parole services are dependent upon community-based agencies to provide support services to parolees, a decrease in or absence of such services reduces the parolees' likelihood of remaining in the community. Given that supervising children in the community is less expensive than incarceration, there are additional financial implications for TYC, as well as other agencies and taxpayers.
- On June 16, 2004, the LBB (Legislative Budget Board) and the Governor's Budget Office instructed state universities and agencies to reduce their General Revenue requests by 5% for the 2006 and 2007 fiscal years (Lavine & DeLuna, 2004). Whereas the 2003 budget crisis resulted from a drop in state General Revenue, the current issues are "man-made" (Lavine & DeLuna, 2004).
- State agencies have submitted budgets for 2006 and 2007, as well as requests for exceptions to the 5% cut in General Revenue requests. If all of the requests and exceptions were granted, the state would require approximately $5 billion in General Revenue, a 16% increase over the current budget (DeLuna, 2004).

- Maintenance of Texas' current services would require an additional $6 billion in revenues and additional revenue would be required to reverse cuts made in 2003, to address issues with child protective services, and reduce local property taxes (Castro, 2005; Kluever, 2005). Even if the Texas did not restore previously cut items and did not make improvements, it would face a shortfall of $1.5 billion (Castro, 2005).

Obviously funding plays an important role in the current dilemma, but, is it the root of the problem? An even closer look reveals several underlying issues, the first being a static tax system. Texas' state and local tax systems are unable to grow in proportion to the economy, resulting in an inability to meet the demand for public services without an increase in taxes (Lavine, 2003). The problem lies in the system's emphasis on taxing goods, not services, which comprise a large portion of the economy (Lavine, 2003). Also, revenue generated by sales tax has declined with the increase in sales via mail and internet (Lavine, 2003). Furthermore, Texas' tax system is the 5th most regressive system in the United States (Lavine, 2003). Perhaps even more disheartening is that if the tax system was able to grow with the economy, it is likely that Texas would not have been faced with a budget deficit in 2003 (Lavine, 2003).

Other relevant issues are related to the nature and structure of Texas government. For example, the Texas Legislature meets biennially, requiring legislators to make many complicated decisions about the next two years in a short period of time. Such a schedule is not conducive to active and rational multi-year problem-solving. The lack of policy forecasting in Texas further limits the ability of legislators to develop a clear understanding of long-term implications and to make rational decisions. Also, political pressure to support "successful" programs fosters reluctance among legislators to support programs that are experimental, risky, or difficult to prove successful. Prevention programs fall into this category due to the difficulty of proving the program diverted clients from another service. All of these factors tend to dampen foresight and creativity, while encouraging reactionary policy making.

Service Delivery in Rural Areas

As discussed in Chapter 1, many of the social issues experienced by rural and urban areas are at least similar, if not the same. However, rural areas tend to possess unique characteristics or factors that exacerbate the social issues and interfere with efforts to alleviate them. These characteristics include, but are not limited to, lack of economic opportunity, limited resources, socio-economic underdevelopment, geographical isolation, geographical barriers, physical distance from services, dependence upon private transportation, lack of public transportation, limited financial resources, culture, resistance to outsiders, archaic technology, centralized services, high caseloads, limited staff and resources, scarcity of trained professionals, and difficulties with recruiting and retaining trained professionals (Carlton-LaNey et al., 1999; Daley & Avant, 1999, 2004; Davis, 2004a; Ginsberg, 1993, 1998; Judd et al., 2002; Nooe & Bolitho, 1982; Poole & More, 2004; Roberts et al., 1999; Rodriguez, Cooper, & Morales, 2004; Scales & Cooper, 1999; Stephen F. Austin State University School of Social Work, 2001; Stuart, 2004; Templeman & Mitchell, 2004; Van Hook & Ford, 1998; Van Wart et al., 2000; Wedel & Bulter, 2004; Whitaker, 1984; Wiesheit et al., 1999; Winship, 2004). Conversely, rural areas also possess unique characteristics that serve as strengths or assets. Examples of such include natural helping networks, a strong "sense of community," intimacy and interdependence among residents, emphasis on self-sufficiency, abundance of personal space, strong family values, faith-based organizations, family oriented business practices, internal focus or interdependence and intergenerational thinking (Aker & Scales, 2004; Daley & Avant, 2004; Davis, 2004; Judd et al., 2002; Murty, 2004; Nooe & Bolitho, 1982; Stephen F. Austin State University School of Social Work, 2001; Templeman & Mitchell, 2004). It is also important to note that some of these characteristics, such as geographical isolation, resistance to outsiders, informal decision-making, informal power structures, slower pace of life, emphasis on traditional values, and preference for acceptance over individuality, may serve as strengths depending on the situation.

Recently, the impact of these characteristics upon the delivery of mental health care services has received attention at the international, national, state and regional levels. Internationally and nationally, the absence or lack of community-based mental health

professionals and services has been credited with increasing the burden of care experienced by families and informal networks (Judd et al., 2002). The characteristics of rural areas are also believed to decrease the effectiveness of case management services (Judd et al., 2002). At the state level, Hopkins and Logan (2006) found that rural areas of Texas face a number of issues when delivering mental health crisis services, including a lack of professionals qualified to deliver mental health and healthcare services, lack of law enforcement officers trained to manage mental health crises, transportation issues (distance and cost), and limited access to alternative service delivery methods, such as telemedicine. Cooper and Avant (2006) found that the Deep East Texas region faced the aforementioned issues, as well as a lack of cooperation among relevant organizations (the local MHA, local hospitals, law enforcement agencies, local courts, and community-based corrections), limited services in outlying areas of the region (mental health and healthcare services tend to be centralized in the larger towns), inconsistencies in expectations and procedures for mental health commitments, amount of time required to complete a mental health commitment, costs of mental health commitments for city and county governments, costs incurred by counties for the provision of psychotropic medications for county jail inmates, narrow eligibility criteria, limited access to psychiatric hospital beds, overuse of local hospital services (emergent care and med/surg beds) for mental health related issues, and the lack of prevention/early intervention services.

The following quotations offered by Hopkins and Logan (2006) exemplify the challenges faced by rural clients, families, and agencies:

- Being in a rural area, the area that we service and West Texas Center's 23-county attachment, everyone well knows that is a tremendous geographical area to cover. When the nursing homes have a crisis in the middle of the night, getting someone to provide services and transportation for those patients is very difficult. I would love to see there be funding for transportation services. Again, when you have systems that are underfunded but you have excellent employees working, the burnout rate can become very high when your resources are as limited as they have been in Texas. *Mary*

Kay McLaughlin, Program Director, Psychiatric Nurse, Geriatric Psychiatric Unit, Scenic Mountain Medical Center (p. 20).

- It is one thing for our office to serve mental health warrants or to pick up someone who is in danger to themselves or others from the street and transport them to the hospital or mental health facility. It is quite another for our officers to transport patients from the hospital to another mental health facility, particularly when the that facility is hundreds of miles away… And while our constable and sheriff deputies are extremely professional, they are not mental health professionals. And a patrol car is not the ideal way to transport someone who is suffering from the illness… Let me remind you that the State of Texas provides transportation for state prisoners from county jails, but it won't provide transportation to those with serious mental illness, some of our most vulnerable residents. *Judge Gilberto Hinojosa, Cameron County* (p. 20).
- We have individuals and family members who express a lot of concern about the distances to a psychiatric hospital. It is difficult for the family to participate in the individual's care when they have to drive four or five hours to get to the local hospital. The closest private care for children from [Andrews] is in San Angelo or Lubbock. If [the person is] indigent, it is a three to five hour drive farther to Wichita Falls or El Paso. *Cindy McGee, President, Andrews NAMI* (p. 20).
- "…Hasn't been too long ago we had a mental health crisis. Couldn't find a bed and finally got one assigned, and they wanted me to transport him to Brownsville, 700 miles away. *Don Corzine, Sheriff, Yoakum County, Texas*." (p. 14).
- The rural hospital staff is not trained to deal with violent behavior. They are not prepared for these types of patients. They need to get them out of there. They don't have the staff availability for one, to be doing one-on-one or two-on-one for a patient. It all comes down to funding for the rural hospitals or for

MHMR. *Tracy Williamson, Director, Social Services, Cogdell Memorial Hospital, Snyder. Public Testimony, February 23, 2006.* (p. 15).

Additional practical examples of the issues faced by rural areas of Texas were provided in earlier discussions of the Special Needs Diversionary Program (SNDP), Texas Integrated Funding Initiative (TIFI), and Community Resource Coordination Groups (CRCG).

While it is reasonable to assume that existing community-based services could utilize interorganizational relationships to overcome the aforementioned barriers and improve the delivery and quality of services to rural children who are at-risk of or possess emotional/behavioral issues, the success of such relationships is dependent upon availability of adequate resources. Unfortunately, the current environment, especially in rural areas, is not conducive to such endeavors. For instance, state and local budget cuts have reduced the funds available to juvenile probation departments, Child Protective Services, and local Mental Health Authorities. The funding reductions have been extremely detrimental to rural areas, especially since they already faced difficulties in generating local revenue to support social service programs. Furthermore, agencies are expected to continue serving the same number of clients, in some cases more, with less financial support. Rural agencies have responded to these conditions with a variety of survival tactics, including narrowing client populations, reducing services, and hoarding resources. As expected, these tactics have resulted in increased competition for resources, interorganizational animosity, reluctance to cooperate with one another, active avoidance of responsibility, and finger pointing. Unfortunately, such conditions are counterproductive to interorganizational relationships and effectively widen the existing "gaps." Thus, rural clients, families, and agencies involved in the mental health and related services find themselves in a precarious situation.

Summary

In Texas the primary providers of services to children with emotional/behavioral issues are the local juvenile probation departments, Texas Youth Commission, Department of Family and Protective Services, local Mental Health Authorities, and

school districts. These agencies currently face three key issues that interfere with their ability to deliver effective services: service fragmentation, deficits in funding and resources necessary for service delivery, and a limited capacity to cover gaps in services. In response to these issues, state and local agencies have narrowed eligibility criteria in order to restrict services to the most severe cases. Some agencies have also imposed limits on the number of clients that can be served at a given time, resulting in eligible clients waiting up to a year before receiving services. More often than not, individuals who are ineligible or placed on a waiting list find their condition worsening before they are able to access appropriate and adequate services. In fact, many of these individuals end up in other less appropriate systems, such as foster care, juvenile probation/detention, TYC, primary healthcare services, and local hospitals. This is especially true for rural areas, which often lack the supplemental resources found in urban counties, i.e., private and non-profit social service organizations and a local tax base capable of supporting additional services. As noted in the following statement by Susan Rushing, Executive Director of Burke Center (the MHA for Deep East Texas), there is also a lack of appropriate supportive care alternatives for those who improve to the point of no longer requiring the MHA's services.

> Burke Center is at capacity. The patients who we've stabilized through our outpatient program could be discharged to their family doctor, but there are no payment sources to cover that care. So we're running the "Hotel California" here- you can check in, but you can't check out and get the care you need. Texas can do better (MHAT, 2005, p. 2-4).

Thus, rural areas are left without adequate resources to provide children with the support they need to become stable and independent adults who are able to contribute to the community.

The obvious solution to the issues facing rural service providers involves closing the "gaps" in services via cooperation among service providers, expansion of existing eligibility criteria and services, and extensive aftercare services. As demonstrated by the literature review, interorganizational relationships appear to be a viable solution to the relationship issues among service providers. However, as noted in the discussion of

practical examples of interorganizational relationships, such interventions require a substantial amount of commitment, time and resources to plan, develop and maintain. In order for the relationship to be successful, the participants would have to address the components of collaboration, including the development and maintenance of trust, effective management of power and politics, development and maintenance of a structure that ensures representation of relevant stakeholders, and appropriate leadership, as well as proactively address the various barriers to collaboration. Clearly this is a difficult endeavor, especially given the barriers to rural service delivery, the underlying issue of funding, and the need for structural changes in state level agencies. On the other hand, can the citizens of Texas afford not to answer the challenge? Vikki Spriggs, the Executive Director of the Texas Juvenile Probation Commission offers the following insight,

> When we look at the results of an underfunded mental health system on the lives of Texas' children, we see human potential that will probably never be realized. We have to find a way to demonstrate a value for all the state's citizens-especially the most vulnerable…. (MHAT, 2005, p. 7-1).

While the solution may be "obvious", as social workers we know that there are several steps that must be completed before formulating and implementing an intervention. In general, we must engage the client, gather data, conduct a comprehensive assessment, and then work with the client to formulate and implement an individualized intervention. Although there are a variety of studies regarding the issues faced by this population, many of which were presented in the preceding chapters, the majority of them were conducted in urban areas with little to no attention to rural areas. Given the unique strengths and issues of rural communities, it is important to assess the needs of rural areas before formulating a solution. The author is hopeful that the dissertation process has addressed this issue while providing local and regional stakeholders an opportunity to share their experiences and insights and subsequently influence local, regional, and state efforts to improve the delivery of social services for children. In addition to the implications for service delivery in rural areas and children with emotional/behavioral issues, this dissertation has the potential to address other

deficits in the knowledge base. For example, the current studies tend to focus on issues from either an organizational, service provider, or client perspective. In contrast, this dissertation involved direct service providers, supervisors, administrators, and parents of clients. Furthermore, Concept Mapping allows for multiple comparisons between the stakeholder groups, resulting in the identification of points of consensus and disagreement. The collection and application of such information is vital to planning and implementing change in service delivery systems and is congruent with social work values and interventions. In summary, the author is hopeful that this dissertation will assist relevant stakeholders in the development of interventions to address the issues stemming from the policies, structures, funding, and other relevant aspects of social services for rural children and their families.

CHAPTER 3- METHODOLOGY

The current study examined the impact of the children's social services system upon the delivery of services to rural East Texas children who are either at-risk of or possess emotional/behavioral issues. Specifically, the study sought to answer the following research questions:

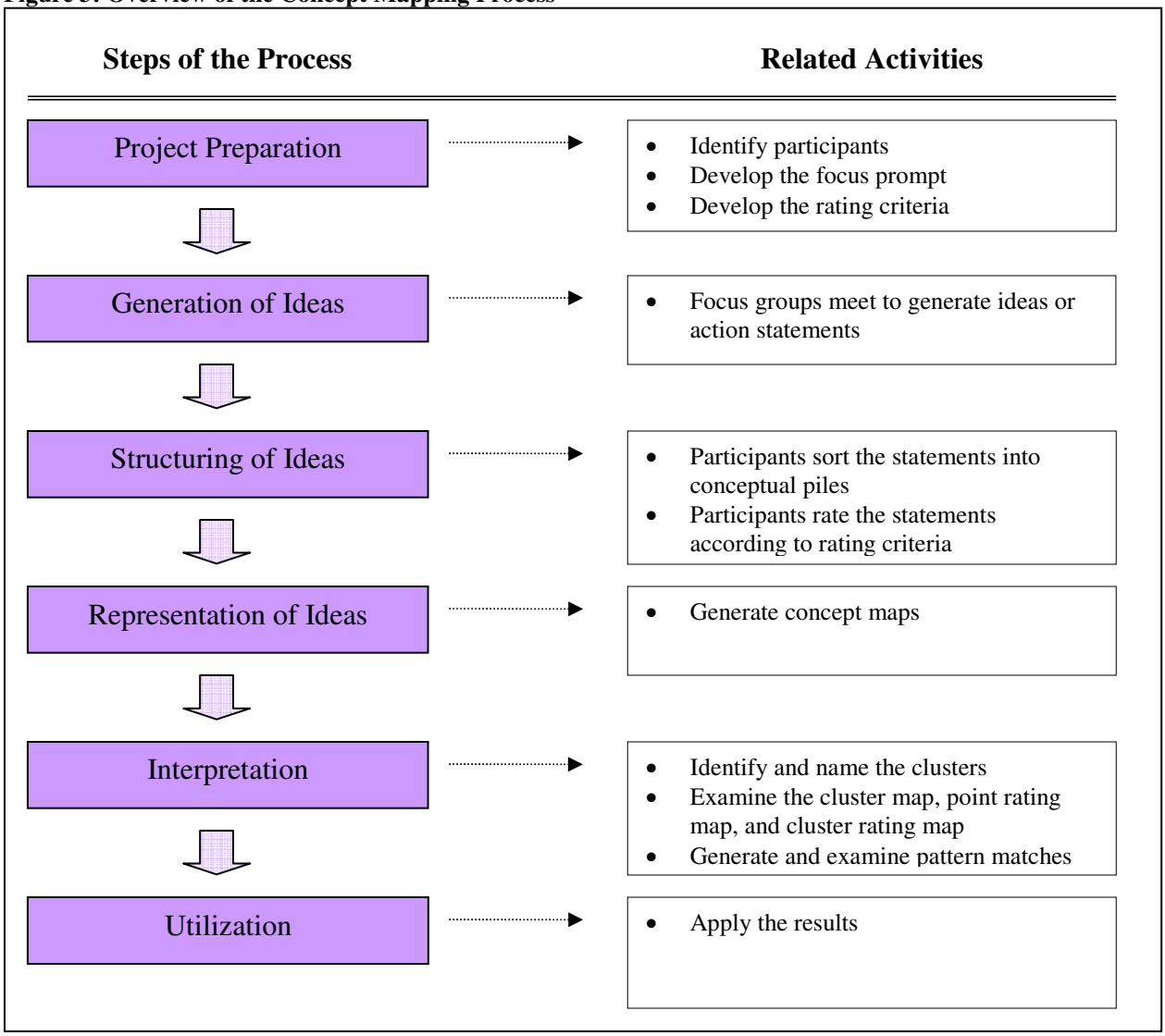
1. *How does the current structure of public social services for children who are at risk of or possess emotional/behavioral issues affect the ability of service providers to develop and maintain interorganizational relationships?*
2. *How does the current structure of public social services for children who are at risk of or possess emotional/behavioral issues affect service delivery to rural East Texas clients and their families?*

The study took place in a rural region of East Texas commonly referred to as Deep East Texas. The region is served by the Deep East Texas Council of Governments (DETCOG) and consists of the following 12 rural counties: Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler. Collectively these rural counties cover 9,906 square miles and have a combined population of approximately 363,222 (U.S. Census Bureau, 2000, 2006). In terms of ethnicity, the population is predominately Caucasian, with African Americans comprising between 9.9% to 27.9% of the population and Hispanics ranging from 1.8% to 14.3% of the population (U.S. Census Bureau, 2000, 2006). It should be noted that the region's Hispanic population has steadily increased over the past 10 years and it is very likely that the population is larger than indicated by the U.S. Census Bureau's data (Cooper & Avant, in press; Rodriguez et al., 2004). The regional economy relies heavily upon agriculture related industries, especially timber and poultry. The 1999 estimated per capita income for the twelve counties ranged from $14,525 to $16,144, which is below that statewide average of $19,617 (U.S. Census Bureau, 2000). In terms of prevalence of children's mental health issues, TDMHMR (2003) projected the following estimates for the region: 2.5% of the children and adolescents will meet the priority population criteria, 11.8% will present with a mental illness, and 20% will present with or be at-risk of mental health problems. The participants were individuals who were involved with

social services for children who are at-risk of or possess emotional/behavioral issues, including service providers, administrators, and parents of children involved with the children's social service system. Additional details regarding participants will be provided in Chapter 4.

The study utilized Concept Mapping to investigate the aforementioned research questions. Concept Mapping is a structured process capable of yielding a conceptual framework that can inform program planning and evaluation (Trochim, 1989). The process utilizes focus groups to generate action statements in response to a focus prompt. For example, the group may be presented with the following prompt: One thing that XYZ Corporation could do to improve its delivery of services is…. The group members would then generate statements that identify specific actions the XYZ Corporation could engage in to improve service delivery. Once the group has identified the actions, the individual members organize the statements in to groups based on conceptual similarity. The participants also rate each of the statements based on criteria developed by the researcher, which in strategic planning projects would probably include the importance of each statement to achieving the focus prompt. This information is then processed using the Concept System® software (© 1989-2007 Concept Systems Inc., All Rights Reserved), which utilizes multi-dimensional scaling and hierarchical cluster analysis to assist the researcher in the identification of conceptual domains or clusters. The end result is the generation of a map depicting the graphical relationships among and between statements. The software also produces statement ratings, cluster ratings, and allows for identification of group similarities and differences, all of which are important to planning and implementing change in service delivery systems. Figure 3 depicts the steps of the Concept Mapping process (Concept Systems, 2004; Trochim, 1989). A detailed description of each step is provided in subsequent sections of this chapter.

Figure 3: Overview of the Concept Mapping Process



Project Preparation

The first step of the planning process is to identify the participants for the focus groups, statement sorting, and statement rating. In order to ensure the study is representative of all relevant stakeholders in the children's social services delivery system, the following groups were invited to participate: parents of clients, direct service workers, supervisors, and administrators. Given the large geographical area and number of participants, multiple focus groups were held throughout the region. Specifically,

focus group meetings were conducted in each of the following towns: Jasper, Livingston, Lufkin, and Nacogdoches. Meetings were also planned for Center and Crockett, but they were cancelled due to a lack of participants. These towns were chosen because they are the most populous ones in the region, they tend to serve as "hubs" of activity for the smaller surrounding towns, and they possess the facilities necessary for the study. Two focus groups were held in each location, the first consisting of parents of clients and the second including social service providers (direct service workers, supervisors, and administrators). Each of the focus groups consisted of 3 to 12 members. The non-probability, purposive sampling process for selecting focus group members is outlined below:

- Parents of clients- This group consisted of parents/guardians of children who were active clients with juvenile probation, juvenile parole, community mental health, school social work/special education, and/or child protective services. In order to select these participants, the researcher contacted the administrator/supervisor for juvenile probation, community mental health services, child protective services, and school social work services in each of the twelve counties. He/she was asked to identify one or two parents of current clients to participate in the study. The criteria for selection included cognitive ability to participate in the all phases of data collection (focus group, sorting, and rating), familiarity with services for children with emotional/behavioral issues, and preferably involvement with multiple services. He/she contacted those individuals and either obtained permission to release their contact information to the researcher or provided them with the researcher's contact information. The researcher then made contact with the potential participants and solicited their involvement. Those who agreed to participate were provided with a letter describing the process (see Appendix A). The letter was either emailed or mailed via the US postal service, depending on each participant's preference.
- Social service providers- This group consisted of direct service workers, supervisors, and administrators from juvenile probation, juvenile parole, community mental health, school social work, and DFPS. In order to select these

participants, the researcher contacted the administrator/supervisor for juvenile probation, community mental health services, child protective services, and school social work services in each of the twelve counties. He/she was asked to identify a current direct services worker, supervisor, and administrator to participate in the study. The researcher then made contact with the potential participants and solicited their involvement. Those who agreed to participate were provided with a letter describing the process (see Appendix A). The letter was either emailed or mailed via the US postal service, depending on each participant's preference.

All of the above participants were invited to participate in the sorting and rating of statements.

Although the sampling process was initially expected to generate between 120 and 180 participants, the loss of two meeting sites and limited interest resulted in 20 focus group participants. In attempt to increase the number of participants, the researcher used the above sampling process to identify additional parents/guardians and service providers to participate in the rating portion of the study. This resulted in an additional 28 participants, bringing the total to 48.

The second item to address during project preparation is the development of a focus statement and focus prompt, both of which serve to guide the focus group sessions and the outcome of the project (Concept Systems, 2004). The focus statement is a brief, action-oriented, and time specific statement that identifies the focus or purpose of the project. The focus prompt is based on the focus statement and serves as a guiding framework for the action statements developed during the focus group sessions. In fact, the action statement actually follows the focus prompt and together they form a complete sentence. In order to fulfill the project's purpose, the following focus statement and prompt were developed:

- Focus Statement- Generate statements (short phrases or sentences) that describe specific factors that impact the ability of public social service providers to work together in the delivery of services to clients who possess or are at-risk of emotional/behavioral issues and their families.

- Focus Prompt- One factor that impacts the ability of public social service providers to work together in the delivery of services to clients and their families is…

The final step of the planning process is to identify the rating criteria for the statements, which usually includes a rating for importance. Given the project's purpose, participants rated each statement's prevalence, allowing for the ranking of statements and conceptual domains or clusters based on perceived prevalence. The participants were also asked to rate their personal response to the statements. The rating criteria are as follows:

- Frequency- How often have you experienced this factor while delivering/receiving services?

  1= None of the time

  2= Very rarely

  3= Some of the time

  4= Most of the time

  5=All of the time

- Response- How would you characterize this factor?

  1= Very discouraging

  2= Discouraging

  3= Neither discouraging, nor encouraging

  4= Encouraging

  5= Very encouraging

Generation of Ideas (Data Collection)

Once the participants are identified and the focus statement, focus prompt, and rating criteria are developed, the project advances to Generation of Ideas, the second step in the Concept Mapping process. This step involves conducting focus group sessions resulting in the generation of action statements based on the focus prompt. As mentioned earlier, twelve focus groups were held throughout the region, each of which met for

approximately 2 hours. The focus group sessions were facilitated by the author, who is certified as a Concept Systems Facilitator by Concept Systems, Inc. and co-facilitated by Freddie L. Avant, LMSW-AP, ACSW, C-SSWS, Ph.D. The schedule for the focus group meetings was as follows:

Nacogdoches (C. L. Simon Recreation Center)	March 26, 2007
Jasper (DETCOG)	March 27, 2007
Livingston (City Hall Meeting Room)	March 30, 2007
Lufkin (Family Counseling Associates)	April 2, 2007

Since Concept Systems recommends that the number of statements fall within a range of 25 to 200, each focus group was expected to generate 25 to 50 statements. To assist with this, the second and subsequent focus groups were provided with a list of the statements to date to help avoid duplication. At the beginning of each session participants were asked to complete a Consent Form and a Participant Information Sheet (see Appendix B and C, respectively). They were also asked to complete a questionnaire designed to gather information about their experiences with public social services for children who possess or are at-risk of emotional/behavioral issues (see Appendix D). Participants were then provided with written instructions for the focus session, which were explained by the facilitator (see Appendix E). At this point, participants were asked to work independently to generate three action statements. When the participants had completed the task, one by one each participant was asked to share one of his or her action statements. Once everyone had shared one statement, the process started over again and continued until each person had shared his/her three statements. As the statements were being read, the facilitator entered them into a word processing program, which was projected on a screen for all to view. When all of the statements had been recorded the group reviewed them and worked together to eliminate duplicate statements. However, the focus group only edited the statements it generated, not the statements produced by previous groups.

Structuring of Ideas (Data Collection)

The third step in the Concept Mapping process is Structuring of Ideas, which consists of sorting and rating the statements generated during the focus group sessions (Generation of Ideas). Sorting and rating are individual activities, both of which occurred during a second focus group meeting. While there was concern that completing both of these tasks in the same meeting may increase the chances of reporting errors due to participant fatigue, a greater concern was participant attrition, the likelihood of which would have increased with a third meeting. In order to maximize participation while minimizing participant fatigue, the meetings were scheduled in two sessions with lunch provided between the sessions. The participants sorted the statements during the first session and rated them during the second session (after lunch). Since sorting and rating are individual activities, separate sessions were not scheduled for parents and service providers. The schedule for the sorting and rating session was:

Jasper (DETCOG)	April 10, 2007
Lufkin (Family Counseling Associates)	April 11, 2007
Nacogdoches (C.L. Simon Recreation Center)	April 12, 2007
Livingston (City Hall)	April 13, 2007

Sorting

The sorting process involves the focus group participants in sorting the action statements into piles or groups based on their perceived conceptual similarity. This was accomplished by providing each participant with a Sorting and Recording Instruction Form (see Appendix F) and a stack of cards (about the size of a standard business card), with each card containing one of the action statements. Each participant received all of the action statements. Once the participants had sorted the statements into piles, they recorded their piles onto a form provided by the facilitator (see Appendix G). The participants also named each of their piles based on the grouping concept or characteristic. It should be noted that 20 participants sorted the statements, resulting in more than the minimum number of sorts (10-15) required to generate a valid analysis (Jackson & Trochim, 2002: Trochim, 1993).

Rating

During the rating process participants were asked to complete two rating instruments, one focusing on prevalence and one focusing on response to each of the identified experiences. Specifically, the participants were to rate each statement using the following criteria:

- Frequency- How often have you experienced this factor while delivering/receiving services?

  1= None of the time

  2= Very rarely

  3= Some of the time

  4= Most of the time

  5=All of the time

- Response- How would you characterize this factor?

  1= Very discouraging

  2= Discouraging

  3= Neither discouraging, nor encouraging

  4= Encouraging

  5= Very encouraging

The frequency and response rating forms are provided in Appendices H and I, respectively. While there is not a required minimum number of raters, data reliability increases as the number of ratings increases (Davis, 2004b). Forty-four individuals participated in the rating process.

Representation of Ideas (Data Analysis)

The fourth step in the Concept Mapping process is Representation of Ideas. This step applies multidimensional scaling and hierarchical cluster analysis to the data collected during the sorting and rating process, resulting in the generation of concept maps or visual representations of the relationships and relevance of the action statements (Davis, 2004b; Trochim, 1989). The concept map consists of clusters that represent

domains of the overall concept being explored (Davis, 2004b). The clusters included in the concept map for this project were identified via the following steps:

- *Creation and review of a cluster replay map.* A maximum and minimum number of clusters were entered into the Concept Mapping Software, which then built a concept map that displays each of the mergers made in order to move from the maximum number of clusters to the minimum number of clusters. The researcher then examined each cluster merger to determine whether or not the clusters "fit" conceptually. The number of clusters in the map was determined by the point at which the mergers no longer "fit." Once the clusters were identified, the cluster labels were selected. See the following sections on Multidimensional Scaling Analysis, Hierarchical Cluster Analysis and Sort Pile Label Analysis for more details.
- *Review of the bridging analysis.* This process generates bridging values, a number that indicates how often or not a statement was sorted with the other statements in the same cluster. In other words, it provides a way to determine the relevance of statements within a cluster and informs the decision regarding the number of clusters to be included in the map. See the following section on Bridging Analysis for more details.

Multidimensional Scaling Analysis

The first step in generating a concept map is to enter the data gathered during the sorting process. The Concept Mapping software then takes this data and creates a binary symmetric similarity matrix for each individual who sorted the statements (Concept Systems, 2004; Trochim, 1989). The matrix simply represents which statements were sorted together (see Trochim, 1989 for details). Each individual binary symmetric similarity matrix is then combined to form an aggregate similarity matrix, which provides an overall representation of the statement groupings (Concept Systems, 2004: Trochim, 1989). In terms of the matrix, the more times a pair of statements is sorted in the same pile, the more similar they were perceived to be by those who sorted statements (Concept

Systems, 2004; Trochim, 1989). On the other hand, the less a pair of statements is sorted in the same pile, the less similar they were perceived to be by the sorters.

The aggregate similarity matrix is important because it serves as the input for the multidimensional scaling analysis, a statistical method that yields a set of points (each point represents an action statement) that are transformed into a bivariate distribution (Trochim, 1989). The distribution is then plotted on an X-Y graph, creating a two dimensional representation of the spatial distances between the action statements, otherwise known as a point map (Concept Systems, 2004; Davis, 2004b; Trochim, 1989). The distance between the action statements represents their perceived similarity. Specifically, the closer they are, the more similar they were perceived to be by the sorters. The multidimensional scaling analysis also produces a stress value or an indicator of the concept map's "fit" with the data. An acceptable range of stress values for Concept Mapping projects is .15 to .35, with the average range being .27 to .30 (Trochim, 1993). See the following resources for a more detailed explanation of multidimensional scaling analysis: Concept Systems, 2004; Davison, 1983; Kruskal & Wish, 1978; Trochim, 1989.

Hierarchical Cluster Analysis

Although the multidimensional scaling analysis results in a point map, it does not generate the cluster map. The first step in generating the cluster map is to use the X-Y coordinates for each action statement as input for a hierarchical agglomerative cluster analysis based on Ward's algorithm (Concept Systems, 2004; Trochim, 1989). In simple terms, the first step of the process treats each action statement as an independent cluster, with each subsequent step consisting of a merger of two clusters until there is only one cluster remaining (Trochim, 1989). At each step of the analysis each action statement is a member of only one cluster. In other words, the clusters do not overlap. The end result of this process is a cluster replay map, which outlines the clusters created by each merger.

Once the cluster replay map has been generated, the researcher(s) must determine the number of clusters to be included in the concept map. The process consists of examining each of the mergers from 20 clusters to 3, each time assessing the conceptual

"fit" of the clusters merged. The number of clusters is determined by the point at which there is no longer agreement among the items of the merged clusters. Given that this process is based on researcher(s) discretion, not on a statistical or mathematical formula, it is somewhat subjective. However, since the cluster mergers are generated by a mathematical process, it is also objective (Jackson & Trochim, 2002).

Bridging Analysis

Another tool to assist the researcher in determining the number of clusters is the bridging analysis. This process assists with map analysis by generating a bridging value for each statement and cluster based on spatial distance (Davis, 2004b). Bridging values for statements serve as an indicator of the statement's relationship or similarity to the other statements on the map. Specifically, the lower the bridging value, the more frequently the statement was sorted with the other statements in the same cluster, giving more value to their location on the map (Davis, 2004b). On the other hand, the higher the bridging value, the more frequently the statement was sorted with statements in other areas of the map (clusters) (Davis, 2004b). Therefore, the statement's connection to other areas of the map may be equivalent to or stronger than its connection to statements within the cluster. While in most cases this indicates that the statement is a central item or tie that binds or bridges other statements and/or clusters together, it may also result from a poorly worded statement (W. M. K. Trochim, personal communication, January 15, 2004).

Sort Pile Label Analysis

The last step in the development of a concept map is labeling the clusters. The Concept Mapping software selects a label for each cluster based on a centroid analysis. Specifically, the software examines each of the individual piles generated during the sorting process and identifies the individual pile that has the best statistical fit with the cluster (W. K. M. Trochim, personal communication, January 16, 2004). The label from this pile is then applied to the cluster. The software also identifies the top ten labels for

each pile, allowing the researcher to choose the label that best fits the cluster. In fact, the researcher has the option to create a new label.

Rating Analyses

The rating analysis utilizes data from the rating instruments to calculate average rating scores for each statement and cluster. The analysis is completed for all of the rating criteria and the results can be graphically represented via the concept maps (point rating map and cluster rating map). A point rating map presents the results for individual statements via stacks of blocks, with a higher stack indicating a higher rating. The cluster rating data is represented by the cluster rating map, which depicts aggregate ratings for the cluster via layers. As with the statements, a greater number of layers indicates a higher aggregate rating for the cluster.

The rating data can also be used to generate pattern matches, a graphical representation of the similarities or differences between participant groups. The comparisons are made with Pearson's *r*, a descriptive statistic that assigns a quantitative value to the strength of the association or relationship between two variables. Pearson's *r* is able to determine the existence of a relationship, strength of the relationship, and its direction (direct or inverse). The strength and direction of the relationship is indicated by the correlation coefficient, a number between -1 and +1. Specifically, the +/- signs denote the relationship. A + indicates a direct relationship (as the score for one variable increases, the score for the other one increases or as one decreases, the other one decreases). A – indicates an indirect relationship (as the score for one variable increases, the score for the other variable decreases). The strength of the relationship is indicated by the coefficient, the higher a positive coefficient and the lower a negative coefficient, the stronger the relationship. The absence of a relationship is indicated by a coefficient of zero. According to MacEachron (1982, p. 132), the guidelines for the degree of association or strength are:

Measure of Association		**Descriptive Adjective**
> 0.00 to 0.20	< -0.00 to –0.20	Very weak or very low
> 0.20 to 0.40	< -0.20 to –0.40	Weak or low

Measure of Association		Descriptive Adjective
> 0.40 to 0.60	< -0.40 to –0.60	Moderate
> 0.60 to 0.80	< -0.60 to –0.80	Strong or high
> 0.80 to 1.0	< -0.80 to –1.0	Very high or very strong

While pattern matches are contingent upon an adequate number of participants, the researcher anticipated the following pattern matches:

- Parents and Service Providers
- Administrators and Supervisors
- Administrators and Direct Service Providers
- Supervisors and Direct Service Providers
- Comparisons among the 12 counties as participant numbers allow
- Comparisons among the various service providers as participant numbers allow (Juvenile Probation, Mental Health Services, Child Protective Services, and Schools)

Interpretation (Participant Feedback)

Interpretation, the fifth step in the Concept Mapping process, involves reviewing the concept maps and other results with participants in order to solicit feedback. The views, interpretations, etc. gained from this session inform the researcher's interpretation of the data and subsequent recommendations. The results and concept maps were reviewed with participants once the preliminary results were compiled. The meeting took place on the afternoon of February 24, 2008 at the Stephen F. Austin State University School of Social Work. Despite multiple advance contacts with participants regarding the meeting and its importance, only four individuals chose to attend. Three of the participants were employed in Angelina County and one was employed in Nacogdoches County. One was an administrator for a local independent school district, one was a juvenile probation officer, and two were direct service providers for the local mental health authority. The format for the meeting is outlined below:

- *Review the Concept Mapping process.* The Concept Mapping process (focus sessions, sorting, and rating) was briefly reviewed with participants to refresh their memory.
- *Review the statement list.* Participants were provided with a list of the action statements generated during the focus sessions and asked to briefly review it.
- *Review the point map.* Participants were presented a point map (a two dimensional representation of the spatial distances between the action statements) and were advised of the analysis used to develop the map and how to interpret the map. Statement numbers were then added to the map so that participants could review statements located closely together and far apart, demonstrating the degree of similarity indicated by distance between points.
- *Review the cluster maps.* A statement list by cluster was then provided along with a cluster point map. The following topics were discussed: hierarchical cluster analysis, how the number of clusters was determined, bridging analysis, and cluster labeling. The discussion yielded a consensus regarding the chosen cluster solution and cluster labels.
- *Review the pattern matches.* Prior to the meeting pattern matches were constructed for both rating scales (frequency and response). The results of these pattern matches were presented and discussed during the meeting.

Utilization (Application of Results)

Utilization, the sixth step in the process, involves using the data to inform a task or project, such as developing an action plan, creating structure for group planning, conducting a needs assessment, developing a program, and evaluating a program (Trochim, 1989). As previously mentioned the current project was designed to examine the impact that the children's social services system has upon the delivery of services to Rural East Texas Children who are either at-risk of or possess emotional/behavioral issues. The resulting data highlight the experiences of service providers and parents exposed to social services for children with emotional/behavioral issues. Not only do the results include specific experiences, they provide insight regarding the frequency and

nature of the experiences. The author is hopeful that the information will prove to be important to those involved in planning, designing and implementing local, regional and state services for children who are at risk of or possess emotional/behavioral issues.

Social Services Questionnaire

In addition to their involvement in the Concept Mapping process, participants were asked to complete a questionnaire designed to gather information about their experiences with public social services for children who possess or are-at risk of emotional/behavioral issues. The questionnaire consisted of five open-ended items that asked participants to discuss positive and negative service delivery situations, things that they would change and keep the same, and perceptions of the difficulty associated with systematic change (see Appendix D). Forty-six of the 48 participants chose to complete the questionnaire. For each of the five questions, the responses were aggregated and reviewed for common themes. Responses were then grouped by common theme and reviewed again for consistency with the related theme. Comparisons were also made among different demographic groups in order to identify similarities and differences in their responses. The results of the analysis are reported in Chapter 4.

CHAPTER 4- FINDINGS

Subjects

As mentioned earlier, the goal of the subject selection process was to create a sample representative of all relevant stakeholder groups, i.e., parents of clients, direct service workers, supervisors, and administrators. The previously described selection process yielded a sample that appears to be representative of all the relevant stakeholder groups, except for parents of clients. Descriptions of the participants for the generation, sorting, and rating of ideas are presented in the following sections.

Generation of Ideas

The selection process resulted in 20 focus group participants. The group consisted of 12 females and 8 males, with an average age of 36.6 (sd= 10.21), and an average monthly household income of $4,605.37 (sd= 2047.01). Additional demographic information is presented below in Tables 1-6.

Table 1: Stakeholder Groups

Categories	Frequency	% of Total
Parent/Guardian of a Client	3	15.0
Service Provider	17	85.0
Other	0	0.0
Missing	0	0.0

Table 2: Race/Ethnicity

Categories	Frequency	% of Total
African American/Black	2	10.0
Asian American/Pacific Islander	0	0.0
Latino/Hispanic	0	0.0
Multiracial	0	0.0
Native American	1	5.0
White/European	17	85.0
Other Group	0	0.0
Missing	0	0.0

Table 3: Education

Categories	Frequency	% of Total
Less than a high school diploma	0	0.0
High school education without a diploma	1	5.0
High school diploma or GED	1	5.0
Trade school/Training program (completed)	0	0.0
Some college, no degree	2	10.0
Associate degree	0	0.0
Bachelor degree	11	55.0
Graduate/professional degree	5	25.0
Missing	0	0.0

Table 4: County of Residence

County	Frequency	% of Total		County	Frequency	% of Total
Angelina	8	40.0		San Augustine	0	0.0
Houston	0	0.0		San Jacinto	0	0.0
Jasper	1	5.0		Shelby	0	0.0
Nacogdoches	6	30.0		Trinity	0	0.0
Newton	1	5.0		Tyler	0	0.0
Polk	1	5.0		Other	1	5.0
Sabine	2	10.0		Missing	0	0.0

Table 5: County of Employment

County	Frequency	% of Total		County	Frequency	% of Total
Angelina	9	45.0		San Augustine	0	0.0
Houston	0	0.0		San Jacinto	0	0.0
Jasper	3	15.0		Shelby	0	0.0
Nacogdoches	5	25.0		Trinity	0	0.0
Newton	0	0.0		Tyler	0	0.0
Polk	2	10.0		Other	0	0.0
Sabine	1	5.0		Missing	0	0.0

Table 6: Employment Status

Categories	Frequency	% of Total
Full-time, with benefits	16	80.0
Full-time, without benefits	3	15.0
Part-time, with benefits	0	0.0
Part-time, without benefits	0	0.0
Seasonal or contract labor	0	0.0
Unemployed	1	5.0
Retired	0	0.0
Other	0	0.0
Missing	0	0.0

Three of the focus group members were parents, who had an average of 3.33 children (sd= 1.53), with an average of 1.67 of those children currently living in their home (sd= .577). None of the children reported as currently residing in the home were

the respondents' grandchildren. There was an average of 3.0 adults living in the home (sd= 1.00), of which an average of 2.33 were actively involved with childcare (sd= .577). Additional demographic information for parents is presented below in Tables 7-9.

Table 7: Average Number of Children Involved with Service Providers

Categories	Average	sd
Local Mental Health Authority	1	1.00
Department of Family and Protective Services	0	0.0
Special Education Services for Emotional Disturbance	1	1.00
Juvenile Probation	1	1.00
Other Service Providers	0	0.0

Table 8: Average Number of Children Currently Involved with Service Providers

Categories	Average	sd
Local Mental Health Authority	.67	1.16
Department of Family and Protective Services	0	0.0
Special Education Services for Emotional Disturbance	.67	1.16
Juvenile Probation	0	0.0
Other Service Providers	0	0.0

Table 9: Current Marital Status

Categories	Frequency	% of Total
Single, never married	0	0.0
Married	2	66.7
Married, but legally separated	0	0.0
Divorced	0	0.0
Widowed	1	33.3
Other	0	0.0
Missing	0	0.0

Seventeen of the focus group members were service providers, who had an average of 9.176 years experience delivering social services to children (sd= 9.20). On average, the service providers had been in their current position 3.7 years (sd= 3.5) and with their current employer 6.3 years (sd= 6.15). Also, eight of the service providers reported having a professional license. Additional demographic information for service providers is presented below in Tables 10-12.

Table 10: Current Employer

Categories	Frequency	% of Total
Local Mental Health Authority	3	17.6
Department of Family and Protective Services	4	23.5
Independent School District	1	5.9
Juvenile Probation	7	41.2
Other	2	11.8
Missing	0	0.0

Table 11: Primary Job Responsibilities

Categories	Frequency	% of Total
Front-line or direct service provider	11	64.7
Supervisor	3	17.6
Administrator	3	17.6
Other	0	0.0
Missing	0	0.0

Table 12: License Types[*]

Categories	Frequency		Categories	Frequency
Attorney	0		MD	0
Clinical Psychologist	0		Occupational Therapist	0
FNP	0		Peace Officer	0
LMFT	0		Physical Therapist	0
LCDC	1		Physician's Assistant	0
LBSW	0		Psychological Associate	0
LMSW	1		RN	0
LMSW-AP	0		Speech Pathologist	0
LCSW	0		Teacher	1
LPC	1		Other License	1
LVN	0			

Sorting of Ideas

All of the individuals who chose to participate in the focus groups were asked to attend the second meeting, which involved sorting and rating the statements generated during the focus group meetings. Most of those individuals attended the second meeting, as well as a few individuals who were unable to attend a focus group meeting. A total of 20 participants sorted statements, resulting in more than the minimum number of sorts (10-15) required to generate a valid analysis (Jackson & Trochim, 2002: Trochim, 1993).

[*] Explanation for abbreviated License Types: FNP (Family Nurse Practitioner), LMFT (Licensed Marriage and Family Therapist), LCDC (Licensed Chemical Dependency Counselor), LBSW (Licensed Bachelor Social Worker), LMSW (Licensed Master Social Worker), LMSW-AP (Licensed Master Social Work-Advanced Practitioner), LCSW (Licensed Clinical Social Worker), LPC (Licensed Professional Counselor), LVN (Licensed Vocational Nurse), MD (Medical Doctor) and RN (Registered Nurse)

The group consisted of 7 males and 13 females, with an average age of 37.4 (sd= 10.52), and an average monthly household income of $5,226.63 (sd= 1976.72). Additional demographic information is presented below in Tables 13-18.

Table 13: Stakeholder Groups

Categories	Frequency	% of Total
Parent/Guardian of a Client	1	5.0
Service Provider	19	95.5
Other	0	0.0
Missing	0	0.0

Table 14: Race/Ethnicity

Categories	Frequency	% of Total
African American/Black	2	10.0
Asian American/Pacific Islander	0	0.0
Latino/Hispanic	0	0.0
Multiracial	0	0.0
Native American	1	5.0
White/European	17	85.0
Other Group	0	0.0
Missing	0	0.0

Table 15: Education

Categories	Frequency	% of Total
Less than a high school diploma	0	0.0
High school education without a diploma	0	0.0
High school diploma or GED	0	0.0
Trade school/Training program (completed)	0	0.0
Some college, no degree	1	5.0
Associate degree	0	0.0
Bachelor degree	12	60.0
Graduate/professional degree	7	35.0
Missing	0	0.0

Table 16: County of Residence

County	Frequency	% of Total		County	Frequency	% of Total
Angelina	6	30.0		San Augustine	0	0.0
Houston	0	0.0		San Jacinto	0	0.0
Jasper	2	10.0		Shelby	0	0.0
Nacogdoches	7	35.0		Trinity	0	0.0
Newton	1	5.0		Tyler	0	0.0
Polk	3	15.0		Other	1	5.0
Sabine	0	0.0		Missing	0	0.0

Table 17: County of Employment

County	Frequency	% of Total		County	Frequency	% of Total
Angelina	7	35.0		San Augustine	0	0.0
Houston	0	0.0		San Jacinto	0	0.0
Jasper	2	10.0		Shelby	0	0.0
Nacogdoches	6	30.0		Trinity	0	0.0
Newton	1	5.0		Tyler	0	0.0
Polk	4	20.0		Other	0	0.0
Sabine	0	0.0		Missing	0	0.0

Table 18: Employment Status

Categories	Frequency	% of Total
Full-time, with benefits	17	85.0
Full-time, without benefits	3	15.0
Part-time, with benefits	0	0.0
Part-time, without benefits	0	0.0
Seasonal or contract labor	0	0.0
Unemployed	0	0.0
Retired	0	0.0
Other	0	0.0
Missing	0	0.0

Since only one of the sorters was a parent, no demographic information will be provided for that category. For the other nineteen, all of whom were service providers, the average number of years experience delivering social services to children was 10.02 (sd= 9.62). On average, the service providers had been in their current position 3.74 years (sd= 3.22) and with their current employer 6.92 years (sd= 7.27). Also, ten of the service providers reported having a professional license. Additional demographic information for service providers is presented below in Tables 19-21.

Table 19: Current Employer

Categories	Frequency	% of Total
Local Mental Health Authority	2	10.5
Department of Family and Protective Services	3	15.8
Independent School District	2	10.5
Juvenile Probation	10	52.6
Other	2	10.5
Missing	0	0.0

Table 20: Primary Job Responsibilities

Categories	Frequency	% of Total
Front-line or direct service provider	12	63.2
Supervisor	3	15.8
Administrator	4	21.1
Other	0	0.0
Missing	0	0.0

Table 21: License Types*

Categories	Frequency		Categories	Frequency
Attorney	0		MD	0
Clinical Psychologist	0		Occupational Therapist	0
FNP	0		Peace Officer	0
LMFT	0		Physical Therapist	0
LCDC	0		Physician's Assistant	0
LBSW	2		Psychological Associate	0
LMSW	1		RN	0
LMSW-AP	0		Speech Pathologist	0
LCSW	0		Teacher	1
LPC	1		Other License	6
LVN	0			

Rating of Ideas

All of the individuals who participated in the focus groups and/or sorted statements were asked to rate the action statements. Twenty-two of these individuals chose to participate in the rating process. As previously mentioned, an additional 22 participants were recruited, bringing the total number of raters to 44. The group consisted of 31 females and 12 males, with an average age of 37.37 (sd= 10.540), and an average monthly household income of $4,558.31 (sd= 1968.16). It should be noted that one participant chose not to provide the requested demographic information. Additional demographic information is presented below in Tables 22-27.

* Explanation for abbreviated License Types: FNP (Family Nurse Practitioner), LMFT (Licensed Marriage and Family Therapist), LCDC (Licensed Chemical Dependency Counselor), LBSW (Licensed Bachelor Social Worker), LMSW (Licensed Master Social Worker), LMSW-AP (Licensed Master Social Work-Advanced Practitioner), LCSW (Licensed Clinical Social Worker), LPC (Licensed Professional Counselor), LVN (Licensed Vocational Nurse), MD (Medical Doctor) and RN (Registered Nurse)

Table 22: Stakeholder Groups

Categories	Frequency	% of Total
Parent/Guardian of a Client	3	6.8
Service Provider	40	90.9
Other	0	97.7
Missing	1	2.3

Table 23: Race/Ethnicity

Categories	Frequency	% of Total
African American/Black	5	11.4
Asian American/Pacific Islander	0	0.0
Latino/Hispanic	1	2.3
Multiracial	1	2.3
Native American	3	6.8
White/European	33	75.0
Other Group	0	0.0
Missing	1	2.3

Table 24: Education

Categories	Frequency	% of Total
Less than a high school diploma	0	0.0
High school education without a diploma	0	0.0
High school diploma or GED	0	0.0
Trade school/Training program (completed)	0	0.0
Some college, no degree	4	9.1
Associate degree	0	0.0
Bachelor degree	26	59.1
Graduate/professional degree	13	29.5
Missing	1	2.3

Table 25: County of Residence

County	Frequency	% of Total		County	Frequency	% of Total
Angelina	11	25.0		San Augustine	1	2.3
Houston	2	4.5		San Jacinto	1	2.3
Jasper	2	4.5		Shelby	0	0.0
Nacogdoches	13	29.5		Trinity	0	0.0
Newton	1	2.3		Tyler	2	4.5
Polk	7	15.9		Other	2	4.5
Sabine	1	2.3		Missing	1	2.3

Table 26: County of Employment

County	Frequency	% of Total		County	Frequency	% of Total
Angelina	13	29.5		San Augustine	1	2.3
Houston	1	2.3		San Jacinto	1	2.3
Jasper	2	4.5		Shelby	0	0.0
Nacogdoches	11	25.0		Trinity	1	2.3
Newton	1	2.3		Tyler	0	0.0
Polk	11	25.5		Other	0	0.0
Sabine	1	2.3		Missing	1	2.3

Table 27: Employment Status

Categories	Frequency	% of Total
Full-time, with benefits	38	86.4
Full-time, without benefits	3	6.8
Part-time, with benefits	0	0.0
Part-time, without benefits	2	4.5
Seasonal or contract labor	0	0.0
Unemployed	0	0.0
Retired	0	0.0
Other	0	0.0
Missing	1	2.3

Three of the raters were parents, who had an average of 4.67 children (sd= 2.517), with an average of 1.5 of those children currently living in their home (sd= .707). None of the children reported as currently residing in the home were the respondents' grandchildren. There was an average of 2.33 adults living in the home (sd= .577), of which an average of 2.00 were actively involved with childcare (sd= 1.00). Additional demographic information for parents is presented below in Tables 28-30.

Table 28: Average Number of Children Involved with Service Providers

Categories	Average	sd
Local Mental Health Authority	.50	.71
Department of Family and Protective Services	.50	.71
Special Education Services for Emotional Disturbance	0	0.0
Juvenile Probation	1.0	1.41
Other Service Providers	0	0.0

Table 29: Average Number of Children Currently Involved with Service Providers

Categories	Average	sd
Local Mental Health Authority	.5	.71
Department of Family and Protective Services	.50	.71
Special Education Services for Emotional Disturbance	0	0.0
Juvenile Probation	.50	.71
Other Service Providers	0	0.0

Table 30: Current Marital Status

Categories	Frequency	% of Total
Single, never married	0	0.0
Married	2	66.7
Married, but legally separated	0	0
Divorced	1	1
Widowed	0	0
Other	0	0
Missing	0	0

Forty of the raters were service providers, who had an average of 8.36 years experience delivering social services to children (sd= 7.95). On average, the service providers had been in their current position 2.87 years (sd= 2.79) and with their current employer 5.24 years (sd= 5.87). Also, 19 of the service providers reported having a professional license. Additional demographic information for service providers is presented below in Tables 31-33.

Table 31: Current Employer

Categories	Frequency	% of Total
Local Mental Health Authority	12	30.0
Department of Family and Protective Services	12	30.0
Independent School District	2	5.0
Juvenile Probation	12	30.0
Other	2	5.0
Missing	0	0.0

Table 32: Primary Job Responsibilities

Categories	Frequency	% of Total
Front-line or direct service provider	29	72.5
Supervisor	7	17.5
Administrator	4	10.0
Other	0	0.0
Missing	0	0.0

Table 33: License Types[*]

Categories	Frequency		Categories	Frequency
Attorney	0		MD	0
Clinical Psychologist	0		Occupational Therapist	0
FNP	0		Peace Officer	0
LMFT	1		Physical Therapist	0
LCDC	1		Physician's Assistant	0
LBSW	6		Psychological Associate	0
LMSW	1		RN	0
LMSW-AP	0		Speech Pathologist	0
LCSW	0		Teacher	2
LPC	3		Other License	8
LVN	0			

[*] Explanation for abbreviated License Types: FNP (Family Nurse Practitioner), LMFT (Licensed Marriage and Family Therapist), LCDC (Licensed Chemical Dependency Counselor), LBSW (Licensed Bachelor Social Worker), LMSW (Licensed Master Social Worker), LMSW-AP (Licensed Master Social Work-Advanced Practitioner), LCSW (Licensed Clinical Social Worker), LPC (Licensed Professional Counselor), LVN (Licensed Vocational Nurse), MD (Medical Doctor) and RN (Registered Nurse)

Generation of Ideas

As previously noted, 20 individuals chose to participate in one of four focus group sessions, resulting in the generation of 118 statements. The statements were formulated by participants, who were asked to complete the following focus prompt: "One factor that impacts the ability of public social service providers to work together in the delivery of services to clients and their families is…." Table 34 presents the statements in the order they were generated.

Table 34: Statements

1. the tendency of service providers to not look outside the box for possible answers or solutions to client issues
2. the limited number of service providers for clients
3. the limited number of local out-of-home placements for clients
4. the high number of at-risk students compared to the limited time available to serve them
5. the high number of at-risk students compared to the limited resources available to serve them
6. the willingness of the client to participate with service providers
7. the willingness of the client's parents to participate with service providers
8. the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions
9. limited access to client transportation
10. current collaborative efforts via Community Resource Coordination Group (CRCG)
11. current collaborative efforts via CASA (Court Appointed Special Advocates)
12. current collaborative efforts via Nacogdoches Safe and Drug Free
13. the client's ability to pay for services
14. the lack of access to service providers within close proximity to rural areas
15. service providers' limited familiarity with services
16. families' limited familiarity with services
17. the lack of follow through with services from families
18. the lack of follow through with services from professionals
19. the unwillingness of Medicaid to provide comprehensive coverage to clients
20. the lack of consequences for parents who are not actively involved in services for their children
21. the lack of support groups to help parents develop the skills they need to help their child
22. the lack of community-based mentors to work with the child and service providers
23. the lack of school-based mentors to work with the child and service providers
24. current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)
25. the lack of school-based resources to serve children identified as LD (learning disabled)
26. the lack of school-based resources to serve children identified as ED (emotionally disturbed)
27. the distances families have to travel in order to receive services
28. the tendency of agencies to work against each other instead of together
29. Memorandums of Understanding (MOUs)
30. interagency staff meetings

31. the lack of financial support available in the community to support service delivery
32. the willingness of clients to make substantive changes recommended by service providers
33. the willingness of parents to make substantive changes recommended by service providers
34. the willingness of families to make substantive changes recommended by service providers
35. the use of mutual (interagency) training sessions to clarify agency policies
36. the use of mutual (interagency) training sessions to clarify agency responsibilities
37. the limited availability of services in the local community
38. the tendency to rush to judge clients and their problems because of the opinions of entities involved with the clients
39. decentralized client services
40. centralized client services
41. the lack of familiarity among service providers with the nature of rural areas
42. reluctance of agencies to engage in staffings for common clients
43. reluctance of agencies to communicate with one another
44. the limited understanding of the policies of other agencies
45. the limited understanding of the procedures of other agencies
46. the limited understanding of the responsibilities of other agencies
47. the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)
48. the high turnover rate of service providers
49. the need for more home-based (in-home) services
50. too much emphasis on paperwork
51. the knowledge of available services
52. the lack of community based aftercare services to support clients once they are released from an out-of-home placement
53. the ability of agencies to work together to serve the client and family
54. the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)
55. the degree to which agencies will allow for creativity in working with clients and their families
56. familiarity with the processes of other agencies involved with the client
57. mutual respect among agencies involved in delivering services to the client
58. openness to the views of other agencies involved in delivering services to the client
59. openness to the approaches of other agencies involved in delivering services to the client
60. the ability of agencies to start where the client is
61. the ability of service providers to start where the client is
62. limited coverage of health insurance for mental health issues
63. limited access to health insurance for clients
64. the distance clients must travel to access services
65. the lack of communication between the school district and parents
66. the lack of cooperation between the school district and mental health service providers
67. the limited amount of time allowed by school districts for mental health service providers to meet with clients
68. the unwillingness of school districts to allow mental health service providers to meet with clients at school
69. the lack of family therapy services for mental health clients
70. the lack of parent involvement with their children
71. the limited amount of time available per client due to service delivery expectations

72. the lack of local funding for mental health services
73. the lack of state funding for mental health services
74. the lack of federal funding for mental health services
75. shorter stays for inpatient psychiatric services
76. limited Medicaid coverage for inpatient psychiatric services
77. limited insurance coverage for inpatient psychiatric services
78. the lack of support services for clients
79. the lack of support services for families
80. the lack of summer support programs for clients
81. the lack of summer support programs for families
82. state legislators' limited understanding of mental health disorders
83. service providers' limited understanding of mental health disorders
84. families' limited understanding of mental health disorders
85. the general public's limited understanding of mental health disorders
86. low wages for service providers
87. the lack of crisis services in locations that are easily accessible to clients
88. the lack of inpatient crisis stabilization services
89. limitations created by inconsistencies in agency confidentiality policies
90. the lack of communication among agencies
91. the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization
92. understaffing
93. the lack of appropriately trained staff
94. the lack of agencies' knowledge of services provided by other agencies
95. limited availability of services in rural areas
96. a lack of interagency training
97. an inability to educate the rural population of available resources
98. the lack of a clear understanding of which agencies are responsible for what problems
99. the inconsistencies between allocation of staff resources and client needs
100. the limited amount of time available to provide for the needs of clients and their families
101. the unwillingness of providers to alter services to better meet the needs of clients
102. service duplication
103. the lack of local public awareness campaigns for children's mental health disorders
104. the lack of local public awareness campaigns for children's mental health services
105. the inability to spend the necessary amount of time with each individual case
106. the lack of funding for collaborative projects
107. the unwillingness of agencies to accept responsibility for the difficult cases
108. the disconnect between current funding streams and client needs
109. the ability to find funding to meet the needs of individual counties
110. the lack of funding to provide adequate services to clients
111. high caseloads
112. the unwillingness of schools to cooperate with social service providers
113. the lack of communication among service providers
114. the lack of advocates at the state level
115. the lack of community-based parenting classes
116. inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services
117. the lack of mental health services for clients who don't have a payer source
118. the lack of prevention services

Structuring and Representation of Ideas

Point Map

Once all of the focus groups had met and generated the statements, the sorting process was initiated. This involved 20 participants sorting the statements into piles based on their perceived conceptual similarity. The sorting process results were then entered into the Concept Mapping software and a point map was generated via a multidimensional scaling analysis. Figure 4 is the resulting point map without statement numbers and Figure 5 is the point map with statement numbers (these numbers coincide with those noted in Tables 34, 35, 37, 38, and 39). When examining the point maps, keep in mind that the spatial distance between each point represents the degree of perceived similarity. In other words, the closer two points are, the more similar they were perceived to be by the sorters and the farther apart two points are, the less similar they were perceived to be by the sorters. As previously noted, the multidimensional scaling analysis also generates a stress value, which is an indicator of the map's validity or "fit" with the data. The map's stress value of .26611 falls within the acceptable range of 1.5 to 3.5 and below the average range of .27 to .30 (Trochim, 1993).

Figure 4: Point Map (Without Statement Numbers)

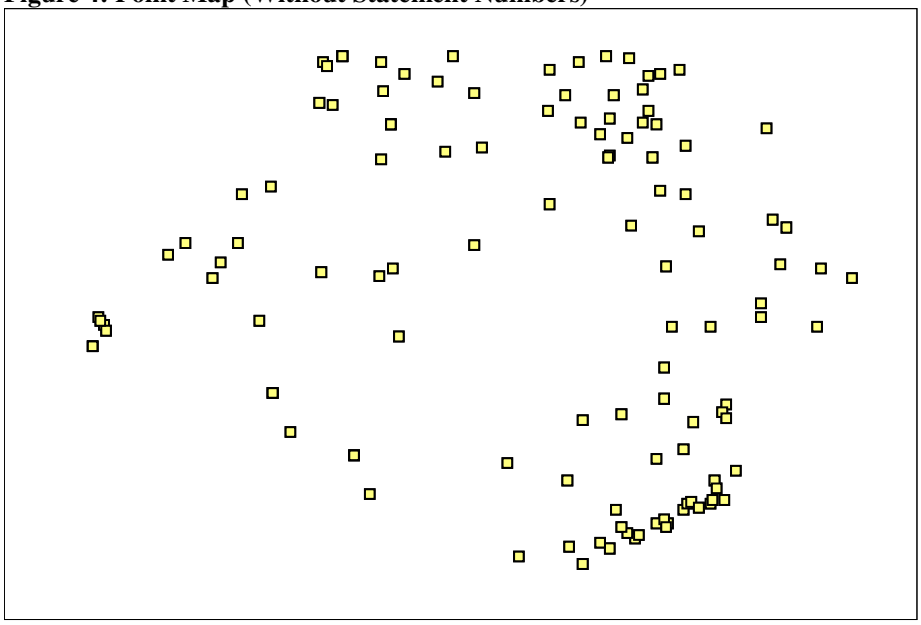
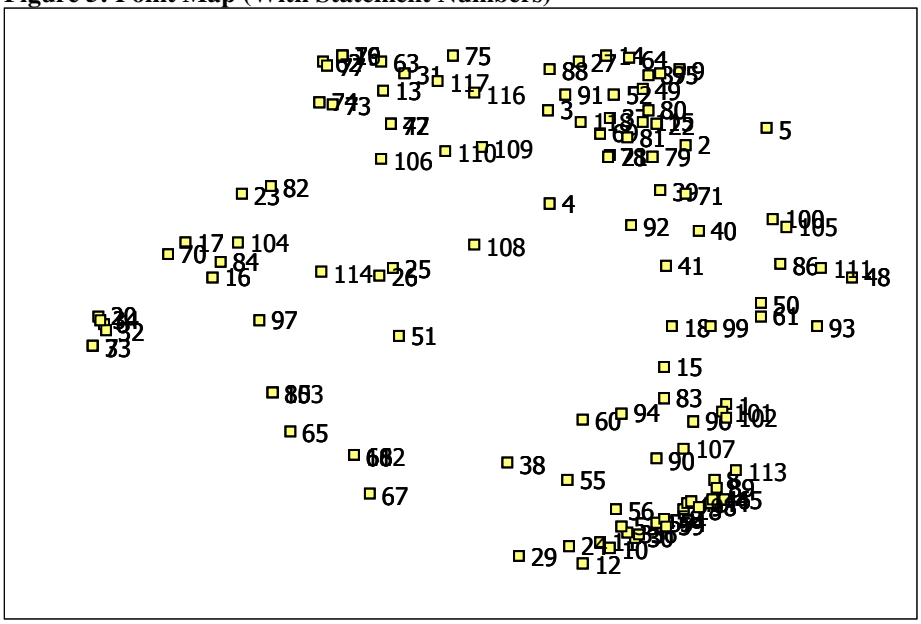


Figure 5: Point Map (With Statement Numbers)



Cluster Map

After the point map was generated, the Concept Mapping software was employed to conduct a hierarchical cluster analysis and create a cluster replay map. As noted earlier, the cluster replay process consists of merging two clusters until the specified minimum number of clusters is reached. The output from the cluster replay informs the decision regarding the number of clusters to be included in the cluster map by allowing the researcher to examine the conceptual "fit" of each merger. In the current study, the cluster replay map began with 25 clusters and reduced it to 4 clusters (see Table 35 for the 25 cluster solution). The decision to accept a merger was based on the conceptual "fit" of the statements contained in each of the clusters. Table 36 provides an overview of the cluster replay, including the clusters merged and the common theme for each merger.

While each merger from 25 to 10 clusters combined items with a common theme, the merger at cluster 9 was questionable. Specifically, it combined two themes, agency barriers to service delivery (clusters 5 and 6) and agencies working together (clusters 7 and 8). On one hand, it made sense to stop the merger process at 10 clusters, which

would keep these two themes separate. On the other hand, the merger created a broader common theme of organizational factors and subsequent mergers also appeared logical. For example, the merger at cluster 8 brought together all of the family related matters, the merger at cluster 7 combined all of the school related items, and the merger at cluster 6 merged all of the organizational factors. Since subsequent mergers would have resulted in the combination of clusters that were not conceptually similar, a 6 cluster map was chosen. The decision was also informed by the bridging values (see Appendix J for the bridging analysis results).

Table 35: Statements by Cluster (25 Cluster Solution)

Cluster 1	
1.	the tendency of service providers to not look outside the box for possible answers or solutions to client issues
96.	a lack of interagency training
101.	the unwillingness of providers to alter services to better meet the needs of clients
102.	service duplication
Cluster 2	
15.	service providers' limited familiarity with services
18.	the lack of follow through with services from professionals
83.	service providers' limited understanding of mental health disorders
99.	the inconsistencies between allocation of staff resources and client needs
Cluster 3	
55.	the degree to which agencies will allow for creativity in working with clients and their families
38.	the tendency to rush to judge clients and their problems because of the opinions of entities involved with the client
Cluster 4	
60.	the ability of agencies to start where the client is
90.	the lack of communication among agencies
94.	the lack of agencies' knowledge of services provided by other agencies
107.	the unwillingness of agencies to accept responsibility for the difficult cases
Cluster 5	
8.	the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions
44.	the limited understanding of the policies of other agencies
45.	the limited understanding of the procedures of other agencies
46.	the limited understanding of the responsibilities of other agencies
89.	limitations created by inconsistencies in agency confidentiality policies
113.	the lack of communication among service providers
Cluster 6	
28.	the tendency of agencies to work against each other instead of together
42.	reluctance of agencies to engage in staffings for common clients

43. reluctance of agencies to communicate with one another
54. the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)
57. mutual respect among agencies involved in delivering services to the client
58. openness to the views of other agencies involved in delivering services to the client
59. openness to the approaches of other agencies involved in delivering services to the client
98. the lack of a clear understanding of which agencies are responsible for what problems

Cluster 7

10. current collaborative efforts via Community Resource Coordination Group (CRCG)
11. current collaborative efforts via CASA (Court Appointed Special Advocates)
12. current collaborative efforts via Nacogdoches Safe and Drug Free
24. current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)
29. Memorandums of Understanding (MOUs)

Cluster 8

30. interagency staff meetings
35. the use of mutual (interagency) training sessions to clarify agency policies
36. the use of mutual (interagency) training sessions to clarify agency responsibilities
53. the ability of agencies to work together to serve the client and family
56. familiarity with the processes of other agencies involved with the client

Cluster 9

2. the limited number of service providers for clients
5. the high number of at-risk students compared to the limited resources available to serve them
22. the lack of community-based mentors to work with the child and service providers
79. the lack of support services for families
80. the lack of summer support programs for clients
115. the lack of community-based parenting classes

Cluster 10

21. the lack of support groups to help parents develop the skills they need to help their child
37. the limited availability of services in the local community
52. the lack of community based aftercare services to support clients once they are released from an out-of-home placement
69. the lack of family therapy services for mental health clients
78. the lack of support services for clients
81. the lack of summer support programs for families
118. the lack of prevention services

Cluster 11

3. the limited number of local out-of-home placements for clients
27. the distances families have to travel in order to receive services
88. the lack of inpatient crisis stabilization services
91. the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization

Cluster 12

9. limited access to client transportation
14. the lack of access to service providers within close proximity to rural areas
49. the need for more home-based (in-home) services
64. the distance clients must travel to access services
87. the lack of crisis services in locations that are easily accessible to clients
95. limited availability of services in rural areas

Cluster 13

39. decentralized client services
40. centralized client services
41. the lack of familiarity among service providers with the nature of rural areas
71. the limited amount of time available per client due to service delivery expectations
92. understaffing

Cluster 14

48. the high turnover rate of service providers
86. Low wages for service providers
100. the limited amount of time available to provide for the needs of clients and their families
105. the inability to spend the necessary amount of time with each individual case
111. high caseloads

Cluster 15

50. Too much emphasis on paperwork
61. the ability of service providers to start where the client is
93. the lack of appropriately trained staff

Cluster 16

4. the high number of at-risk students compared to the limited time available to serve them
108. the disconnect between current funding streams and client needs

Cluster 17

25. the lack of school-based resources to serve children identified as LD (learning disabled)
26. the lack of school-based resources to serve children identified as ED (emotionally disturbed)
51. the knowledge of available services
114. the lack of advocates at the state level

Cluster 18

65. the lack of communication between the school district and parents
85. the general public's limited understanding of mental health disorders
103. the lack of local public awareness campaigns for children's mental health disorders

Cluster 19

66. the lack of cooperation between the school district and mental health service providers
67. the limited amount of time allowed by school districts for mental health service providers to meet with clients
68. the unwillingness of school districts to allow mental health service providers to meet with clients at school
112. the unwillingness of schools to cooperate with social service providers

Cluster 20

6. the willingness of the client to participate with service providers
7. the willingness of the client's parents to participate with service providers
20. the lack of consequences for parents who are not actively involved in services for their children
32. the willingness of clients to make substantive changes recommended by service providers
33. the willingness of parents to make substantive changes recommended by service providers
34. the willingness of families to make substantive changes recommended by service providers

Cluster 21

16. families' limited familiarity with services
17. the lack of follow through with services from families

70. the lack of parent involvement with their children
84. families' limited understanding of mental health disorders
97. an inability to educate the rural population of available resources
104. the lack of local public awareness campaigns for children's mental health services

Cluster 22

23. the lack of school-based mentors to work with the child and service providers
82. state legislators' limited understanding of mental health disorders

Cluster 23

13. The client's ability to pay for services
31. The lack of financial support available in the community to support service delivery
63. limited access to health insurance for clients
75. shorter stays for inpatient psychiatric services
116. inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services
117. The lack of mental health services for clients who don't have a payer source

Cluster 24

47. The lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)
72. The lack of local funding for mental health services
106. The lack of funding for collaborative projects
109. The ability to find funding to meet the needs of individual counties
110. The lack of funding to provide adequate services to clients

Cluster 25

19. The unwillingness of Medicaid to provide comprehensive coverage to clients
62. limited coverage of health insurance for mental health issues
73. The lack of state funding for mental health services
74. The lack of federal funding for mental health services
76. limited Medicaid coverage for inpatient psychiatric services
77. limited insurance coverage for inpatient psychiatric services

Table 36: Cluster Replay

Number of Clusters	Clusters Merged	Comments
25 to 24 clusters	7, 8	merges clusters with a common theme of "agencies working together"
24 to 23 clusters	14, 15	merges clusters with a common theme of "agency characteristics that are barriers to service providers"
23 to 22 clusters	3, 4	merges clusters with a common theme of "agency environment"
22 to 21 clusters	21, 22	merges clusters with a common theme of "barriers to families"
21 to 20 clusters	1, 2	merges clusters with a common theme of "agency environment/culture"
20 to 19 clusters	5, 6	merges clusters with a common them of "agency barriers"
19 to 18 clusters	9, 10	merges clusters with common themes of "lack of services" or "service deficits"
18 to 17 clusters	23, 24	merges clusters with a common theme of "insurance

		and funding"
17 to 16 clusters	11, 12	merges clusters with a common themes of "lack of services" and " service accessibility"
16 to 15 clusters	18, 19	merges clusters with a common theme of "public relations and schools"
15 to 14 clusters	16, 17	merges clusters with a common theme of "lack of knowledge and services"
14 to 13 clusters	9, 10, 11, 12	merges clusters with a common themes of "lack of services" and "barriers to accessibility"
13 to 12 clusters	1, 2, 3, 4	merges clusters with a common theme of "agency characteristics and barriers"
12 to 11 clusters	23, 24, 25	merges clusters with a common theme of "insurance and funding"
11 to 10 clusters	13, 14, 15	merges clusters with a common theme of "agency characteristics that are barriers to service providers"
10 to 9 clusters	5, 6, 7, 8	merges clusters with a common theme of "organizational factors"
9 to 8 clusters	20, 21, 22	merges clusters with a common theme of "family related barriers and issues"
8 to 7 clusters	16, 17, 18, 19	merger brings all school related items together
7 to 6 clusters	1, 2, 3, 4, 5, 6, 7, 8	merger brings all agency related items together
6 to 5 clusters	16, 17, 18, 19, 20, 21, 22	merges family related items with school related items
5 to 4 clusters	9, 10, 11, 12, 13, 14, 15	merges items related to lack of services with barriers to service delivery

The final step in creating the cluster map was a sort pile label analysis, which resulted in renaming each of the clusters in order to achieve representative labels. The software chose the following labels for the six clusters: Cluster 1: Agency internal barriers, Cluster 2: Preventative services, Cluster 3: Limited amount of time/high demands on agency staff, Cluster 4: Client involvement, Cluster 5: Family involvement and awareness, and Cluster 6: Financial concerns at all levels. After careful review of the statements in each cluster, the cluster labels were modified to more accurately reflect content. The new cluster labels are: Cluster 1: Service Delivery, Cluster 2: Availability of Services, Cluster 3: Organizational Factors, Cluster 4: Public Schools and Public Awareness, Cluster 5: Families, and Cluster 6: Funding. The final cluster map is depicted below by Figure 6 (cluster map without points), Figure 7 (cluster point map without statement numbers), and Figure 8 (cluster point map with statement numbers). Since many of the statement numbers are difficult to discern, Table 37 provides a list of the action statements by cluster.

Figure 6: Cluster Map (Without Points)

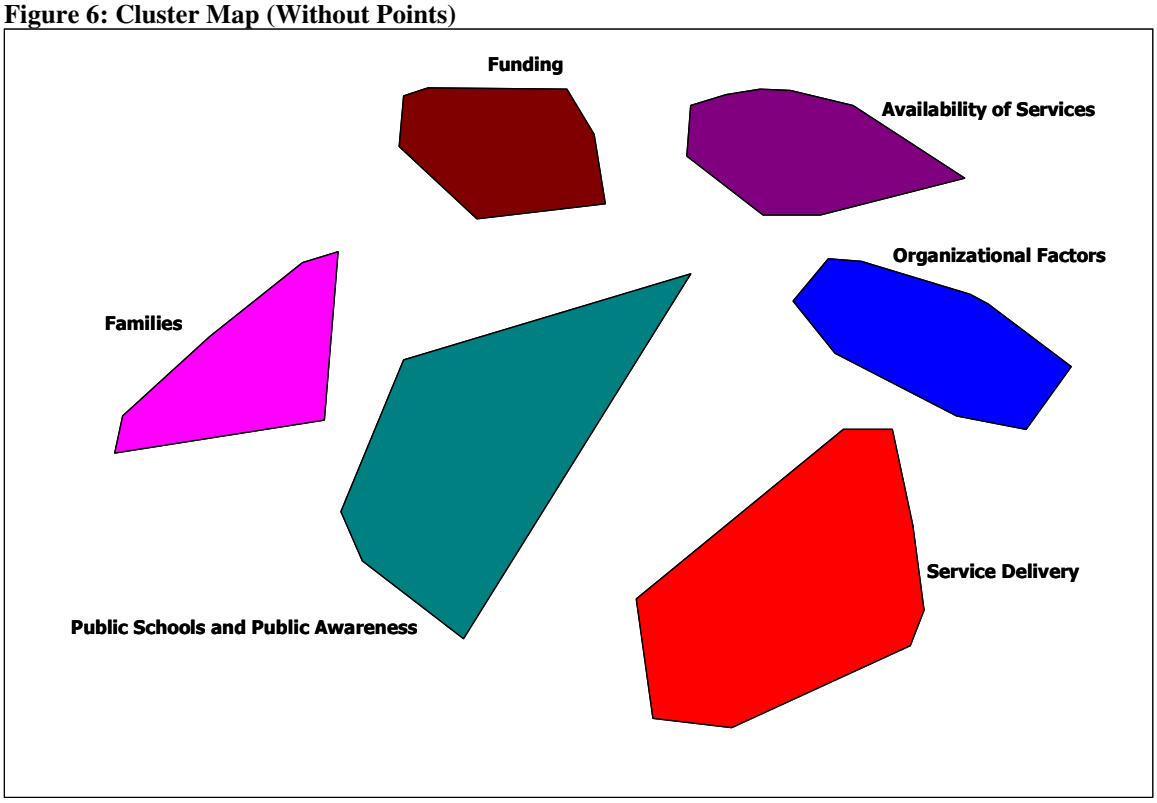


Figure 7: Cluster Point Map (Without Statement Numbers)

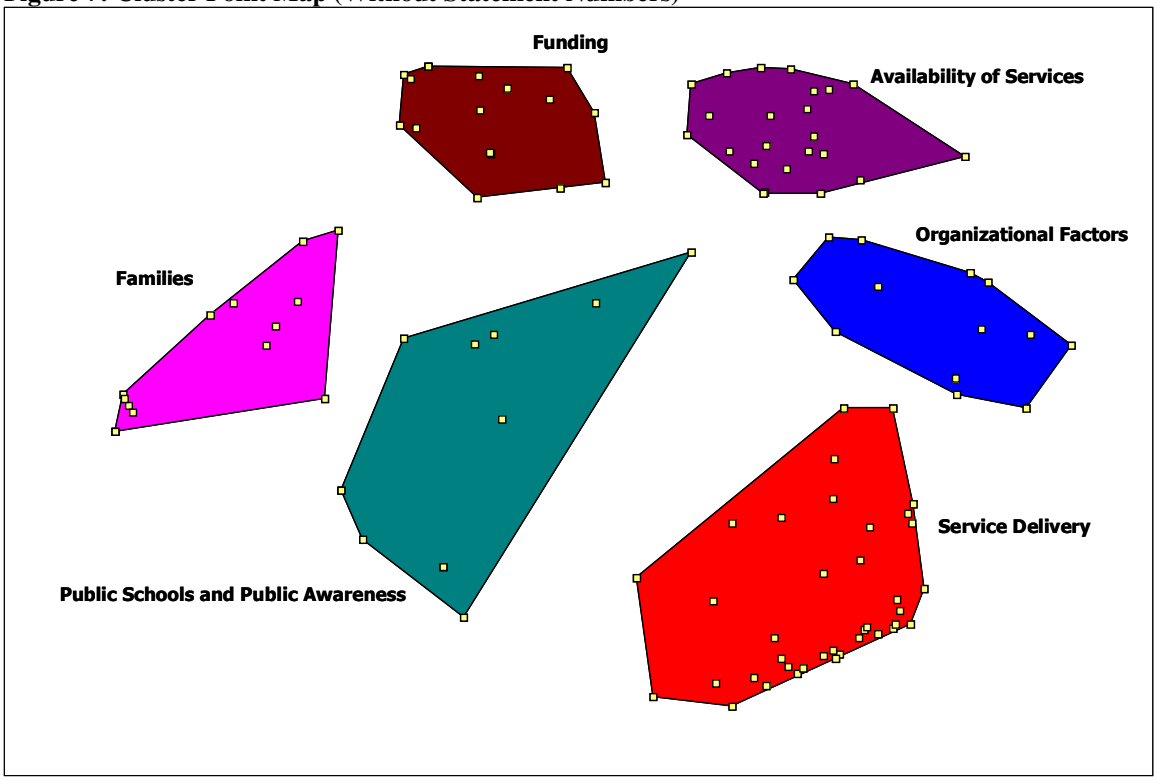


Figure 8: Cluster Point Map (With Statement Numbers)

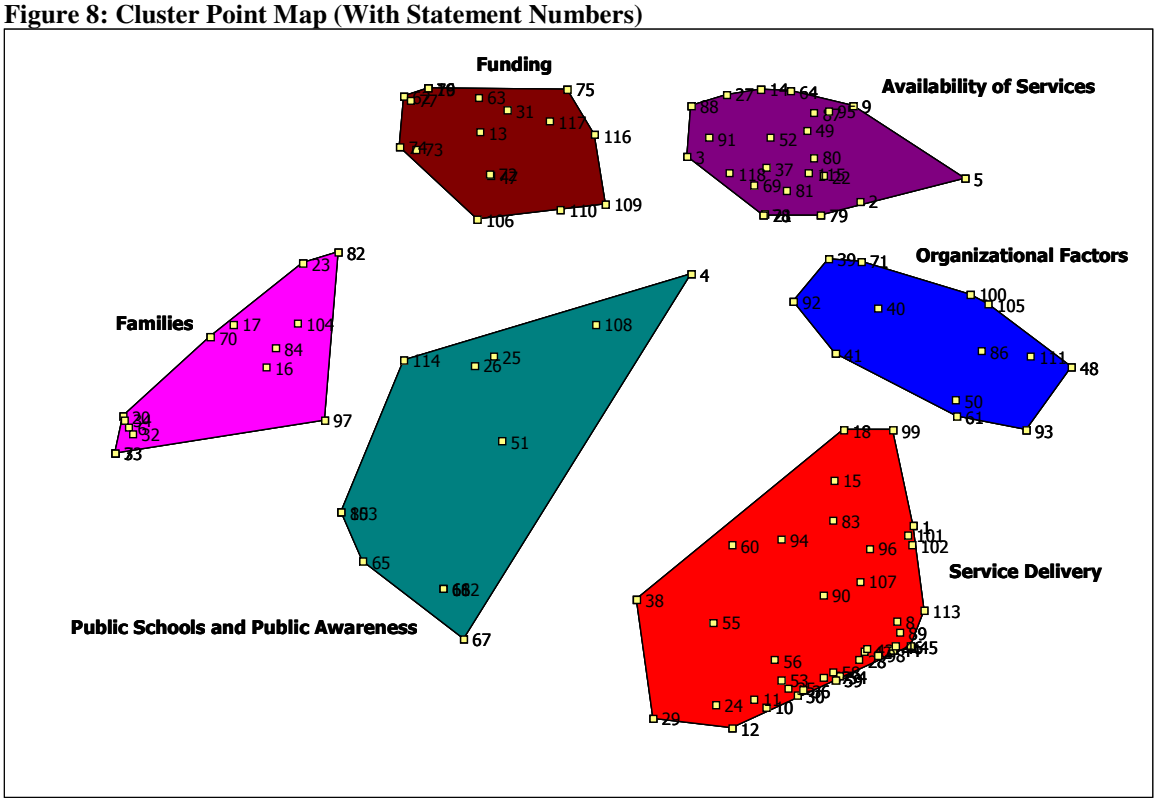


Table 37: Statements by Cluster

Cluster 1: Service Delivery

1. the tendency of service providers to not look outside the box for possible answers or solutions to client issues
8. the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions
10. current collaborative efforts via Community Resource Coordination Group (CRCG)
11. current collaborative efforts via CASA (Court Appointed Special Advocates)
12. current collaborative efforts via Nacogdoches Safe and Drug Free
15. service providers' limited familiarity with services
18. the lack of follow through with services from professionals
24. current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)
28. the tendency of agencies to work against each other instead of together
29. Memorandums of Understanding (MOUs)
30. interagency staff meetings
35. the use of mutual (interagency) training sessions to clarify agency policies
36. the use of mutual (interagency) training sessions to clarify agency responsibilities
38. the tendency to rush to judge clients and their problems because of the opinions of entities involved with the client
42. reluctance of agencies to engage in staffings for common clients
43. reluctance of agencies to communicate with one another
44. the limited understanding of the policies of other agencies
45. the limited understanding of the procedures of other agencies
46. the limited understanding of the responsibilities of other agencies
53. the ability of agencies to work together to serve the client and family

54. the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)
55. the degree to which agencies will allow for creativity in working with clients and their families
56. familiarity with the processes of other agencies involved with the client
57. mutual respect among agencies involved in delivering services to the client
58. openness to the views of other agencies involved in delivering services to the client
59. openness to the approaches of other agencies involved in delivering services to the client
60. the ability of agencies to start where the client is
83. service providers' limited understanding of mental health disorders
89. limitations created by inconsistencies in agency confidentiality policies
90. the lack of communication among agencies
94. the lack of agencies' knowledge of services provided by other agencies
96. a lack of interagency training
98. the lack of a clear understanding of which agencies are responsible for what problems
99. the inconsistencies between allocation of staff resources and client needs
101. the unwillingness of providers to alter services to better meet the needs of clients
102. service duplication
107. the unwillingness of agencies to accept responsibility for the difficult cases
113. the lack of communication among service providers

Cluster 2: Availability of Services

2. the limited number of service providers for clients
3. the limited number of local out-of-home placements for clients
5. the high number of at-risk students compared to the limited resources available to serve them
9. limited access to client transportation
14. the lack of access to service providers within close proximity to rural areas
21. the lack of support groups to help parents develop the skills they need to help their child
22. the lack of community-based mentors to work with the child and service providers
27. the distances families have to travel in order to receive services
37. the limited availability of services in the local community
49. the need for more home-based (in-home) services
52. the lack of community based aftercare services to support clients once they are released from an out-of-home placement
64. the distance clients must travel to access services
69. the lack of family therapy services for mental health clients
78. the lack of support services for clients
79. the lack of support services for families
80. the lack of summer support programs for clients
81. the lack of summer support programs for families
87. the lack of crisis services in locations that are easily accessible to clients
88. the lack of inpatient crisis stabilization services
91. the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization
95. limited availability of services in rural areas
115. the lack of community-based parenting classes
118. the lack of prevention services

Cluster 3: Organizational Factors

39. decentralized client services
40. centralized client services
41. the lack of familiarity among service providers with the nature of rural areas
48. the high turnover rate of service providers
50. too much emphasis on paperwork
61. the ability of service providers to start where the client is

71. the limited amount of time available per client due to service delivery expectations
86. low wages for service providers
92. understaffing
93. the lack of appropriately trained staff
100. the limited amount of time available to provide for the needs of clients and their families
105. the inability to spend the necessary amount of time with each individual case
111. high caseloads

Cluster 4: Public Schools and Public Awareness

4. the high number of at-risk students compared to the limited time available to serve them
25. the lack of school-based resources to serve children identified as LD (learning disabled)
26. the lack of school-based resources to serve children identified as ED (emotionally disturbed)
51. the knowledge of available services
65. the lack of communication between the school district and parents
66. the lack of cooperation between the school district and mental health service providers
67. the limited amount of time allowed by school districts for mental health service providers to meet with clients
68. the unwillingness of school districts to allow mental health service providers to meet with clients at school
85. the general public's limited understanding of mental health disorders
103. the lack of local public awareness campaigns for children's mental health disorders
108. the disconnect between current funding streams and client needs
112. the unwillingness of schools to cooperate with social service providers
114. the lack of advocates at the state level

Cluster 5: Families

6. the willingness of the client to participate with service providers
7. the willingness of the client's parents to participate with service providers
16. families' limited familiarity with services
17. the lack of follow through with services from families
20. the lack of consequences for parents who are not actively involved in services for their children
23. the lack of school-based mentors to work with the child and service providers
32. the willingness of clients to make substantive changes recommended by service providers
33. the willingness of parents to make substantive changes recommended by service providers
34. the willingness of families to make substantive changes recommended by service providers
70. the lack of parent involvement with their children
82. state legislators' limited understanding of mental health disorders
84. families' limited understanding of mental health disorders
97. an inability to educate the rural population of available resources
104. the lack of local public awareness campaigns for children's mental health services

Cluster 6: Funding

13. the client's ability to pay for services
19. the unwillingness of Medicaid to provide comprehensive coverage to clients
31. the lack of financial support available in the community to support service delivery
47. the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)
62. limited coverage of health insurance for mental health issues
63. limited access to health insurance for clients
72. the lack of local funding for mental health services
73. the lack of state funding for mental health services
74. the lack of federal funding for mental health services
75. shorter stays for inpatient psychiatric services
76. limited Medicaid coverage for inpatient psychiatric services

77.	limited insurance coverage for inpatient psychiatric services
106.	the lack of funding for collaborative projects
109.	the ability to find funding to meet the needs of individual counties
110.	the lack of funding to provide adequate services to clients
116.	inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services
117.	the lack of mental health services for clients who don't have a payer source

Statement and Cluster Ratings

As previously discussed, the Concept Mapping software utilizes data from the rating instruments to calculate the average rating score for each statement and cluster. The analysis was completed for all of the rating criteria and the scores are graphically represented by the point rating map and the cluster rating map.

Statement Ratings

The results of the statement rating analysis are depicted by point rating cluster maps, which consist of a point rating map overlaid on a cluster map. The point rating map is similar to a point map, except that each point (statement) is represented by a stack of blocks that indicates the statement's average rating (i.e., the greater the number of blocks in the stack, the higher rating). Each point rating map includes a legend indicating the value of each layer (block) in the stack. The statement numbers were removed from the maps to increase their readability. An overview of the point rating cluster maps is provided below:

- Frequency (see Figure 9)- This map displays the perceived frequency of occurrence for each statement and is based on the responses of all participants who completed the rating instrument. As noted in the map legend, the statement ratings range from 1.86 to 4.27, indicating that overall frequency of encounters with the factors (statements) varied from "none of the time" to "all of the time."
- Response (see Figure 10)- This map displays the participants' responses to each statement and is based on the responses of all participants who completed the rating instrument. The statement ratings range from 1.49 to

3.66, indicating that overall responses to the factors (statements) varied from "very discouraging" to "encouraging."

The average statement ratings for frequency and response are presented in Tables 38 and 39, respectively (see pages 123-132). For each table the statements are grouped by cluster and then listed in order of highest to lowest average score for all participants. In addition to the rating scores for all participants, the tables report the statement ratings for parents and service providers. While the reader is encouraged to examine the comparisons offered in Tables 38 and 39, discussion of such will not appear until later in the dissertation.

Figure 9: Point Rating Cluster Map (Frequency)

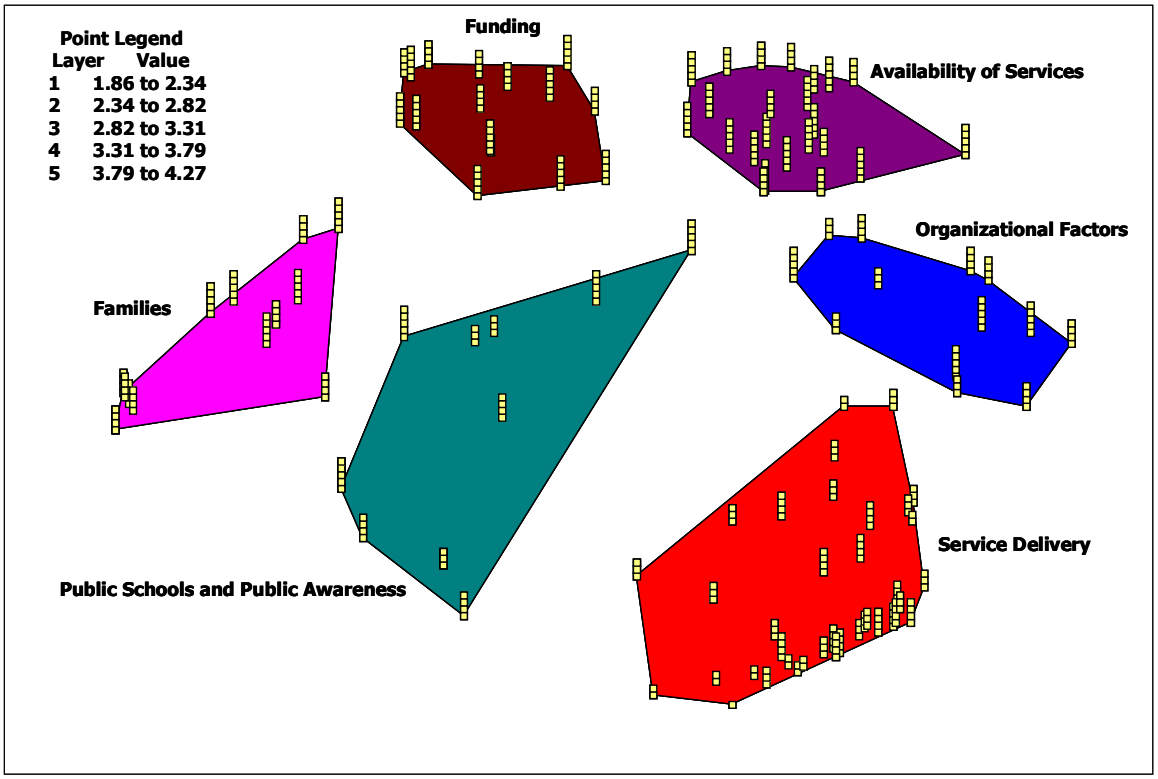
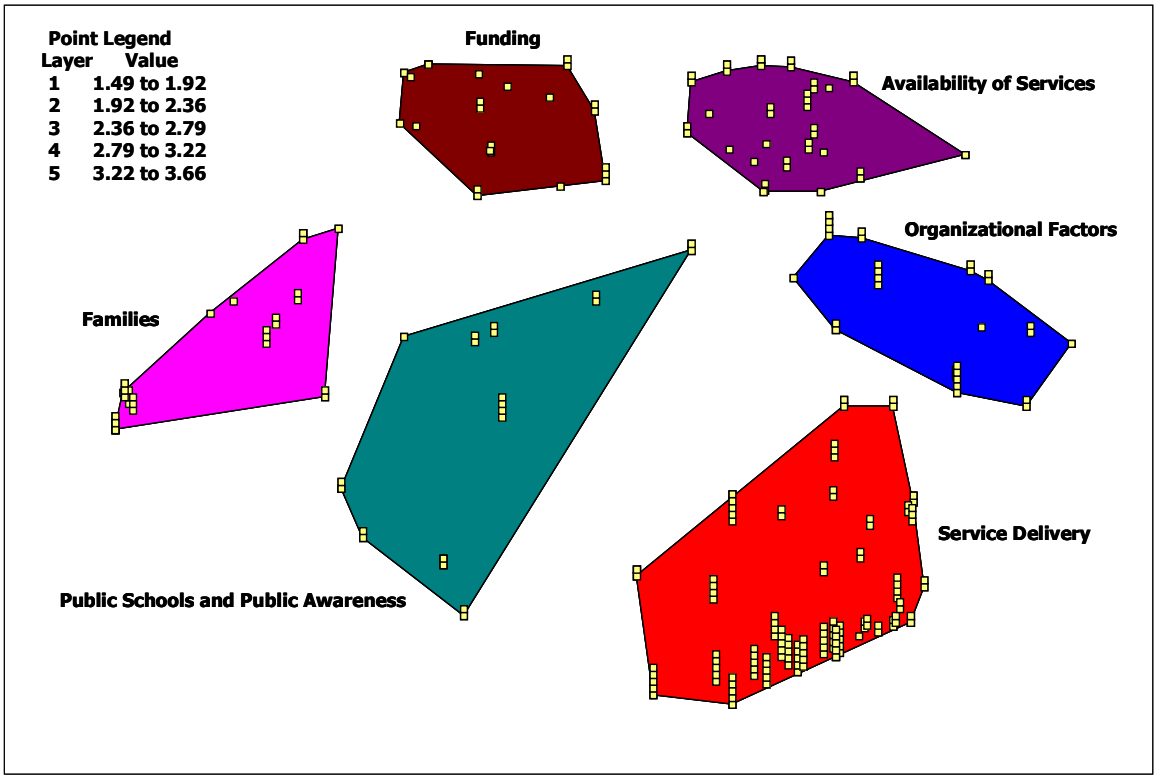


Figure 10: Point Rating Cluster Map (Response)

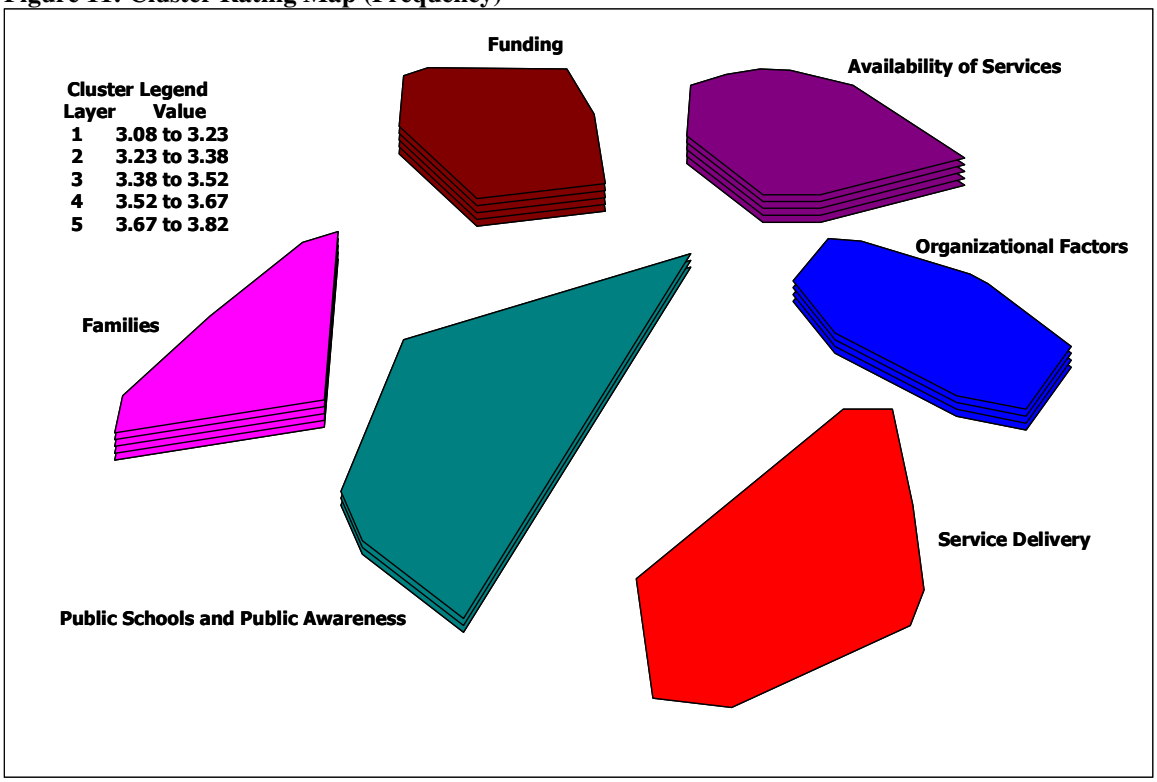


Cluster Ratings

The aggregate rating for each cluster is represented by the cluster rating map. The cluster rating map is similar to a cluster map, except that each cluster is layered to indicate the overall rating (i.e., a greater number of layers indicates a higher aggregate rating for the cluster). Each cluster rating map includes a legend indicating the value of each cluster layer. The first cluster map (Figure 11) displays the aggregate perceived frequency of each cluster and is based on the responses of all participants who completed the rating instrument. At first glance, the clusters with the highest degree of frequency appear to be Availability of Services (Cluster 2), Families (Cluster 5), and Funding (Cluster 6), followed by Organizational Factors (Cluster 3), Public Schools and Public Awareness (Cluster 4), and Service Delivery (Cluster 1). However, further examination reveals that the range represented by the cluster layers is 3.08 to 3.82, meaning that each cluster is fairly similar in terms of frequency. In fact, one could reasonably state that overall the clusters are perceived as being equal in terms of frequency. In terms of resolving issues in service delivery, the results suggest that each cluster should be given

equal consideration, with specific decisions being based upon statement rating data (reported in Tables 38 and 39). Finally, the aggregate standard deviations for each cluster indicates agreement among participants. The aggregate cluster ratings and standard deviations are reported in Table 38 (see p. 123-127).

Figure 11: Cluster Rating Map (Frequency)



The second cluster rating map (Figure 12) depicts the perceived overall response to the factors (statements) and is based on the responses of all participants who completed the rating instrument. The most positive or "encouraging" response was to Service Delivery (Cluster 1), followed by Organizational Factors (Cluster 3), Families (Cluster 5), Public Schools and Public Awareness (Cluster 4), Funding (Cluster 6), and Availability of Services (Cluster 2). As with frequency, the range represented by the cluster layers is fairly narrow (1.89 to 2.73), indicating that the clusters were perceived as being "very discouraging" to "neither discouraging, nor encouraging." Furthermore, the aggregate standard deviations for each cluster indicates agreement among participants (see Table 39 on p. 128-132). The broad implication for problem solving is that the

clusters should be given equal consideration when planning interventions, with specific decisions being based upon statement rating data (reported in Tables 38 and 39).

Figure 12: Cluster Rating Map (Response)

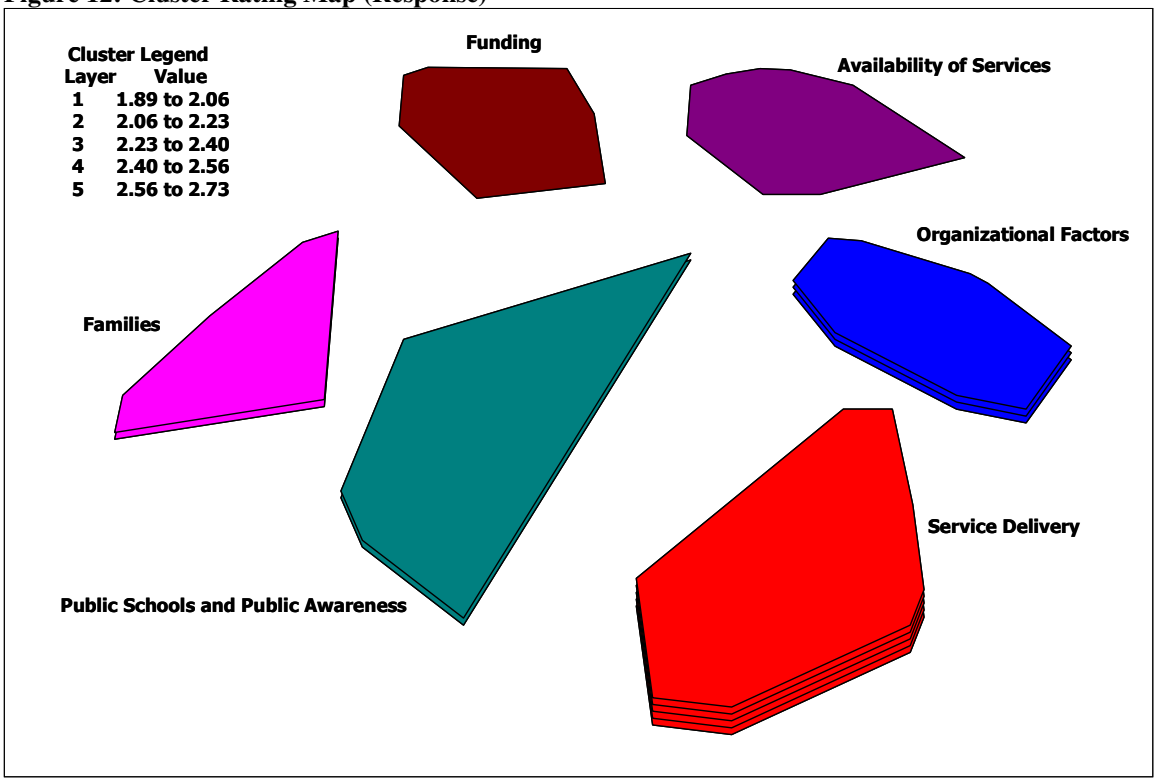


Table 38: Statement Ratings by Frequency

#	Cluster/Statement	All	Parents	Providers
	Cluster 1: Service Delivery			
44.	the limited understanding of the policies of other agencies	3.52	2.67	3.58
45.	the limited understanding of the procedures of other agencies	3.52	2.67	3.58
46.	the limited understanding of the responsibilities of other agencies	3.52	2.67	3.58
94.	the lack of agencies' knowledge of services provided by other agencies	3.48	2.33	3.58
59.	openness to the approaches of other agencies involved in delivering services to the client	3.41	2.67	3.45
58.	openness to the views of other agencies involved in delivering services to the client	3.41	2.67	3.45
90.	the lack of communication among agencies	3.41	2.00	3.50
96.	a lack of interagency training	3.41	2.67	3.53
98.	the lack of a clear understanding of which agencies are responsible for what problems	3.40	2.00	3.44
54.	the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)	3.39	3.67	3.38
107.	the unwillingness of agencies to accept responsibility for the difficult cases	3.37	3.67	3.33
53.	the ability of agencies to work together to serve the client and family	3.36	3.33	3.38
57.	mutual respect among agencies involved in delivering services to the client	3.27	2.67	3.33
99.	the inconsistencies between allocation of staff resources and client needs	3.27	3.00	3.28
8.	the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions	3.26	3.33	3.25
113.	the lack of communication among service providers	3.23	2.33	3.28
101.	the unwillingness of providers to alter services to better meet the needs of clients	3.21	2.67	3.26
55.	the degree to which agencies will allow for creativity in working with clients and their families	3.20	2.33	3.25
38.	the tendency to rush to judge clients and their problems because of the opinions of entities involved with the client	3.19	3.33	3.15
43.	reluctance of agencies to communicate with one another	3.16	2.33	3.20
60.	the ability of agencies to start where the client is	3.14	2.00	3.23
83.	service providers' limited understanding of mental health disorders	3.09	2.00	3.18
42.	reluctance of agencies to engage in staffings for common clients	3.09	2.67	3.10
1.	the tendency of service providers to not look outside the box for possible answers or solutions to client issues	3.09	2.67	3.13
56.	familiarity with the processes of other agencies involved with the client	3.07	2.67	3.08

1 = None of the time 2 = Very rarely 3 = Some of the time 4 = Most of the time 5 = All of the time

#	Cluster/Statement	All	Parents	Providers
89.	limitations created by inconsistencies in agency confidentiality policies	3.07	2.33	3.10
10.	current collaborative efforts via Community Resource Coordination Group (CRCG)	2.95	2.33	3.00
15.	service providers' limited familiarity with services	2.93	2.67	2.95
28.	the tendency of agencies to work against each other instead of together	2.84	3.00	2.80
102.	service duplication	2.80	1.67	2.88
30.	interagency staff meetings	2.79	1.67	2.90
18.	the lack of follow through with services from professionals	2.77	2.67	2.78
24.	current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)	2.67	2.33	2.66
29.	Memorandums of Understanding (MOUs)	2.52	1.67	2.61
36.	the use of mutual (interagency) training sessions to clarify agency responsibilities	2.50	1.67	2.53
35.	the use of mutual (interagency) training sessions to clarify agency policies	2.45	1.33	2.50
11.	current collaborative efforts via CASA (Court Appointed Special Advocates)	2.35	2.33	2.31
12.	current collaborative efforts via Nacogdoches Safe and Drug Free	1.86	1.33	1.92
	Cluster Average	***3.08***	***2.47***	***3.11***
	Standard Deviations	***0.37***	***0.57***	***0.38***
	Cluster 2: Availability of Services			
118.	the lack of prevention services	4.16	4.67	4.13
91.	the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization	4.05	4.67	4.00
5.	the high number of at-risk students compared to the limited resources available to serve them	4.02	5.00	3.95
115.	the lack of community-based parenting classes	4.00	4.67	3.95
21.	the lack of support groups to help parents develop the skills they need to help their child	4.00	4.00	4.00
3.	the limited number of local out-of-home placements for clients	3.95	4.33	3.93
81.	the lack of summer support programs for families	3.88	3.33	3.92
95.	limited availability of services in rural areas	3.86	4.33	3.85
69.	the lack of family therapy services for mental health clients	3.86	3.67	3.87
88.	the lack of inpatient crisis stabilization services	3.86	4.67	3.79
2.	the limited number of service providers for clients	3.84	4.33	3.80
49.	the need for more home-based (in-home) services	3.84	4.67	3.78
80.	the lack of summer support programs for clients	3.81	3.33	3.87
37.	the limited availability of services in the local community	3.80	4.33	3.75
79.	the lack of support services for families	3.77	4.00	3.78
87.	the lack of crisis services in locations that are easily accessible to clients	3.75	4.67	3.68

#	Cluster/Statement	All	Parents	Providers
14.	the lack of access to service providers within close proximity to rural areas	3.75	4.33	3.70
22.	the lack of community-based mentors to work with the child and service providers	3.75	4.33	3.70
78.	the lack of support services for clients	3.73	3.33	3.75
52.	the lack of community based aftercare services to support clients once they are released from an out-of-home placement	3.60	4.33	3.54
64.	the distance clients must travel to access services	3.59	4.33	3.53
27.	the distances families have to travel in order to receive services	3.57	4.33	3.50
9.	limited access to client transportation	3.43	3.00	3.45
	Cluster Average	***3.82***	***4.20***	***3.79***
	Standard Deviations	***0.17***	***0.52***	***0.17***
	Cluster 3: Organizational Factors			
86.	low wages for service providers	4.27	4.33	4.28
111.	high caseloads	3.95	4.67	3.93
50.	too much emphasis on paperwork	3.91	4.00	3.90
92.	understaffing	3.82	3.67	3.83
100.	the limited amount of time available to provide for the needs of clients and their families	3.74	4.00	3.72
105.	the inability to spend the necessary amount of time with each individual case	3.70	3.00	3.75
71.	the limited amount of time available per client due to service delivery expectations	3.70	3.00	3.75
48.	the high turnover rate of service providers	3.66	3.00	3.70
93.	the lack of appropriately trained staff	3.42	2.67	3.46
61.	the ability of service providers to start where the client is	3.11	2.00	3.18
41.	the lack of familiarity among service providers with the nature of rural areas	3.09	2.33	3.13
39.	decentralized client services	2.98	2.00	3.03
40.	centralized client services	2.98	2.33	3.00
	Cluster Average	***3.56***	***3.15***	***3.59***
	Standard Deviations	***0.40***	***0.86***	***0.38***
	Cluster 4: Public Schools and Public Awareness			
4.	the high number of at-risk students compared to the limited time available to serve them	3.93	4.67	3.90
85.	the general public's limited understanding of mental health disorders	3.91	4.00	3.90
108.	the disconnect between current funding streams and client needs	3.86	4.67	3.79
114.	the lack of advocates at the state level	3.83	3.33	3.89
103.	the lack of local public awareness campaigns for children's mental health disorders	3.82	4.33	3.78

#	Cluster/Statement	All	Parents	Providers
65.	the lack of communication between the school district and parents	3.50	2.67	3.55
51.	the knowledge of available services	3.34	3.67	3.30
67.	the limited amount of time allowed by school districts for mental health service providers to meet with clients	3.32	3.00	3.35
26.	the lack of school-based resources to serve children identified as ED (emotionally disturbed)	3.25	3.33	3.25
66.	the lack of cooperation between the school district and mental health service providers	3.25	3.33	3.25
112.	the unwillingness of schools to cooperate with social service providers	3.11	3.33	3.10
25.	the lack of school-based resources to serve children identified as LD (learning disabled)	3.11	3.00	3.13
68.	the unwillingness of school districts to allow mental health service providers to meet with clients at school	3.09	3.33	3.08
	Cluster Average	***3.49***	***3.56***	***3.48***
	Standard Deviations	***0.32***	***0.63***	***0.32***
	Cluster 5: Families			
82.	state legislators' limited understanding of mental health disorders	4.05	4.67	4.00
70.	the lack of parent involvement with their children	3.98	4.33	3.95
17.	the lack of follow through with services from families	3.86	4.33	3.83
16.	families' limited familiarity with services	3.86	4.67	3.83
104.	the lack of local public awareness campaigns for children's mental health services	3.86	4.33	3.82
84.	families' limited understanding of mental health disorders	3.73	3.67	3.73
20.	the lack of consequences for parents who are not actively involved in services for their children	3.73	3.67	3.73
23.	the lack of school-based mentors to work with the child and service providers	3.68	4.33	3.63
7.	the willingness of the client's parents to participate with service providers	3.64	3.67	3.63
33.	the willingness of parents to make substantive changes recommended by service providers	3.57	3.00	3.60
34.	the willingness of families to make substantive changes recommended by service providers	3.52	3.33	3.53
97.	an inability to educate the rural population of available resources	3.51	3.33	3.54
32.	the willingness of clients to make substantive changes recommended by service providers	3.48	3.33	3.48
6.	the willingness of the client to participate with service providers	3.34	3.00	3.38
	Cluster Average	***3.70***	***3.83***	***3.69***
	Standard Deviations	***0.20***	***0.57***	***0.18***
	Cluster 6: Funding			
73.	the lack of state funding for mental health services	4.07	4.67	4.03
117.	the lack of mental health services for clients who don't have a payer source	4.05	4.67	4.03
74.	the lack of federal funding for mental health services	4.00	4.67	3.95

#	Cluster/Statement	All	Parents	Providers
72.	the lack of local funding for mental health services	3.98	4.67	3.95
110.	the lack of funding to provide adequate services to clients	3.91	4.33	3.88
106.	the lack of funding for collaborative projects	3.86	3.67	3.87
109.	the ability to find funding to meet the needs of individual counties	3.82	3.67	3.83
77.	limited insurance coverage for inpatient psychiatric services	3.80	3.33	3.85
75.	shorter stays for inpatient psychiatric services	3.80	3.33	3.83
62.	limited coverage of health insurance for mental health issues	3.68	3.33	3.70
31.	the lack of financial support available in the community to support service delivery	3.68	4.67	3.60
76.	limited Medicaid coverage for inpatient psychiatric services	3.61	3.33	3.63
63.	limited access to health insurance for clients	3.52	3.33	3.53
116.	inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services	3.49	3.33	3.51
13.	the client's ability to pay for services	3.39	3.00	3.40
47.	the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)	3.24	3.00	3.24
19.	the unwillingness of Medicaid to provide comprehensive coverage to clients	3.07	2.67	3.08
	Cluster Average	***3.70***	***3.75***	***3.70***
	Standard Deviations	***0.28***	***0.68***	***0.27***

Table 39: Statement Ratings by Response

#	Cluster/Statement	All	Parents	Providers
	Cluster 1: Service Delivery			
10.	current collaborative efforts via Community Resource Coordination Group (CRCG)	3.66	4.00	3.68
30.	interagency staff meetings	3.60	3.33	3.66
11.	current collaborative efforts via CASA (Court Appointed Special Advocates)	3.56	4.00	3.57
24.	current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)	3.55	4.00	3.53
59.	openness to the approaches of other agencies involved in delivering services to the client	3.49	3.00	3.56
60.	the ability of agencies to start where the client is	3.44	3.33	3.49
58.	openness to the views of other agencies involved in delivering services to the client	3.44	3.00	3.51
57.	mutual respect among agencies involved in delivering services to the client	3.42	2.67	3.51
36.	the use of mutual (interagency) training sessions to clarify agency responsibilities	3.37	3.00	3.44
54.	the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)	3.37	3.33	3.41
12.	current collaborative efforts via Nacogdoches Safe and Drug Free	3.33	3.00	3.40
35.	the use of mutual (interagency) training sessions to clarify agency policies	3.33	2.67	3.41
29.	Memorandums of Understanding (MOUs)	3.29	3.33	3.29
53.	the ability of agencies to work together to serve the client and family	3.23	3.67	3.23
8.	the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions	3.19	3.00	3.23
55.	the degree to which agencies will allow for creativity in working with clients and their families	3.19	2.67	3.26
56.	familiarity with the processes of other agencies involved with the client	3.14	3.00	3.18
102.	service duplication	2.51	2.33	2.53
15.	service providers' limited familiarity with services	2.49	3.33	2.44
113.	the lack of communication among service providers	2.35	3.00	2.31
89.	limitations created by inconsistencies in agency confidentiality policies	2.31	3.33	2.26
44.	the limited understanding of the policies of other agencies	2.30	3.33	2.23
45.	the limited understanding of the procedures of other agencies	2.28	3.33	2.21
38.	the tendency to rush to judge clients and their problems because of the opinions of entities involved with the client	2.28	3.33	2.21
96.	a lack of interagency training	2.26	3.33	2.21
99.	the inconsistencies between allocation of staff resources and client needs	2.26	3.00	2.21

1 = Very discouraging 2 = Discouraging 3 = Neither discouraging, nor encouraging 4 = Encouraging 5 = Very encouraging

#	Cluster/Statement	All	Parents	Providers
1.	the tendency of service providers to not look outside the box for possible answers or solutions to client issues	2.26	3.00	2.21
94.	the lack of agencies' knowledge of services provided by other agencies	2.19	3.67	2.08
46.	the limited understanding of the responsibilities of other agencies	2.19	3.33	2.10
42.	reluctance of agencies to engage in staffings for common clients	2.19	3.33	2.10
90.	the lack of communication among agencies	2.14	3.33	2.08
18.	the lack of follow through with services from professionals	2.12	2.67	2.08
101.	the unwillingness of providers to alter services to better meet the needs of clients	2.12	3.33	2.05
98.	the lack of a clear understanding of which agencies are responsible for what problems	2.10	3.00	2.03
83.	service providers' limited understanding of mental health disorders	2.02	2.00	2.03
107.	the unwillingness of agencies to accept responsibility for the difficult cases	2.00	3.00	1.92
43.	reluctance of agencies to communicate with one another	1.98	2.67	1.92
28.	the tendency of agencies to work against each other instead of together	1.88	3.00	1.79
	Cluster Average	***2.73***	***3.15***	***2.72***
	Standard Deviations	***0.61***	***0.17***	***0.66***
	Cluster 2: Availability of Services			
49.	the need for more home-based (in-home) services	2.74	3.33	2.72
52.	the lack of community based aftercare services to support clients once they are released from an out-of-home placement	2.24	3.00	2.21
9.	limited access to client transportation	2.14	3.33	2.05
2.	the limited number of service providers for clients	2.12	3.67	2.00
27.	the distances families have to travel in order to receive services	2.12	2.67	2.10
64.	the distance clients must travel to access services	2.10	2.67	2.08
14.	the lack of access to service providers within close proximity to rural areas	2.02	2.33	2.03
87.	the lack of crisis services in locations that are easily accessible to clients	2.02	3.00	1.95
21.	the lack of support groups to help parents develop the skills they need to help their child	2.00	2.33	2.00
88.	the lack of inpatient crisis stabilization services	1.98	2.67	1.92
3.	the limited number of local out-of-home placements for clients	1.98	3.67	1.87
80.	the lack of summer support programs for clients	1.98	3.33	1.87
81.	the lack of summer support programs for families	1.98	3.33	1.87
115.	the lack of community-based parenting classes	1.93	2.67	1.90
37.	the limited availability of services in the local community	1.91	2.67	1.87
22.	the lack of community-based mentors to work with the child and service providers	1.91	3.00	1.85

#	Cluster/Statement	All	Parents	Providers
69.	the lack of family therapy services for mental health clients	1.86	2.67	1.79
5.	the high number of at-risk students compared to the limited resources available to serve them	1.83	3.33	1.74
118.	the lack of prevention services	1.81	2.33	1.79
79.	the lack of support services for families	1.81	3.33	1.72
91.	the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization	1.79	2.67	1.72
95.	limited availability of services in rural areas	1.79	2.67	1.74
78.	the lack of support services for clients	1.77	3.00	1.69
	Cluster Average	***1.99***	***2.94***	***1.93***
	Standard Deviations	***0.20***	***0.40***	***0.22***
	Cluster 3: Organizational Factors			
61.	the ability of service providers to start where the client is	3.37	3.33	3.41
40.	centralized client services	2.95	3.00	2.97
39.	decentralized client services	2.93	4.00	2.87
41.	the lack of familiarity among service providers with the nature of rural areas	2.28	3.33	2.23
50.	too much emphasis on paperwork	2.19	3.67	2.08
100.	the limited amount of time available to provide for the needs of clients and their families	2.19	3.00	2.13
111.	high caseloads	2.09	2.67	2.05
93.	the lack of appropriately trained staff	2.09	2.67	2.05
105.	the inability to spend the necessary amount of time with each individual case	2.00	3.00	1.95
71.	the limited amount of time available per client due to service delivery expectations	1.93	3.00	1.87
48.	the high turnover rate of service providers	1.88	3.33	1.79
92.	understaffing	1.81	2.67	1.74
86.	low wages for service providers	1.67	2.33	1.62
	Cluster Average	***2.26***	***3.08***	***2.21***
	Standard Deviations	***0.49***	***0.44***	***0.52***
	Cluster 4: Public Schools and Public Awareness			
51.	the knowledge of available services	2.86	3.00	2.90
112.	the unwillingness of schools to cooperate with social service providers	2.28	3.00	2.23
68.	the unwillingness of school districts to allow mental health service providers to meet with clients at school	2.21	3.00	2.15
66.	the lack of cooperation between the school district and mental health service providers	2.21	2.67	2.15
25.	the lack of school-based resources to serve children identified as LD (learning disabled)	2.19	2.67	2.15

#	Cluster/Statement	All	Parents	Providers
67.	the limited amount of time allowed by school districts for mental health service providers to meet with clients	2.16	2.67	2.13
4.	the high number of at-risk students compared to the limited time available to serve them	2.10	3.33	2.03
103.	the lack of local public awareness campaigns for children's mental health disorders	2.07	2.67	2.05
108.	the disconnect between current funding streams and client needs	2.00	2.67	1.97
26.	the lack of school-based resources to serve children identified as ED (emotionally disturbed)	1.98	2.33	1.95
65.	the lack of communication between the school district and parents	1.98	1.67	2.00
85.	the general public's limited understanding of mental health disorders	1.91	2.67	1.87
114.	the lack of advocates at the state level	1.81	2.33	1.79
	Cluster Average	***2.13***	***2.67***	***2.11***
	Standard Deviations	***0.25***	***0.39***	***0.26***
	Cluster 5: Families			
32.	the willingness of clients to make substantive changes recommended by service providers	2.63	3.33	2.62
6.	the willingness of the client to participate with service providers	2.63	2.67	2.64
34.	the willingness of families to make substantive changes recommended by service providers	2.58	3.33	2.56
33.	the willingness of parents to make substantive changes recommended by service providers	2.49	3.00	2.49
16.	families' limited familiarity with services	2.37	3.00	2.33
7.	the willingness of the client's parents to participate with service providers	2.31	2.00	2.34
97.	an inability to educate the rural population of available resources	2.21	3.33	2.16
104.	the lack of local public awareness campaigns for children's mental health services	2.07	2.33	2.05
23.	the lack of school-based mentors to work with the child and service providers	2.07	3.00	2.00
84.	families' limited understanding of mental health disorders	1.98	2.67	1.92
17.	the lack of follow through with services from families	1.81	3.00	1.74
82.	state legislators' limited understanding of mental health disorders	1.67	2.33	1.62
20.	the lack of consequences for parents who are not actively involved in services for their children	1.65	1.67	1.67
70.	the lack of parent involvement with their children	1.56	2.33	1.51
	Cluster Average	***2.15***	***2.71***	***2.12***
	Standard Deviations	***0.36***	***0.50***	***0.38***
	Cluster 6: Funding			
109.	the ability to find funding to meet the needs of individual counties	2.37	1.67	2.46
13.	the client's ability to pay for services	2.26	1.67	2.31
116.	inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric	2.24	3..00	2.21

#	Cluster/Statement	All	Parents	Providers
	services versus those who were discharged from private inpatient psychiatric services			
47.	the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)	2.12	3.00	2.05
106.	the lack of funding for collaborative projects	2.12	3.00	2.08
75.	shorter stays for inpatient psychiatric services	2.02	3.00	1.95
31.	the lack of financial support available in the community to support service delivery	1.90	2.00	1.92
76.	limited Medicaid coverage for inpatient psychiatric services	1.88	3.00	1.79
19.	the unwillingness of Medicaid to provide comprehensive coverage to clients	1.86	3.00	1.77
77.	limited insurance coverage for inpatient psychiatric services	1.81	3.00	1.72
110.	the lack of funding to provide adequate services to clients	1.77	2.33	1.74
63.	limited access to health insurance for clients	1.74	2.67	1.67
117.	the lack of mental health services for clients who don't have a payer source	1.74	2.33	1.72
62.	limited coverage of health insurance for mental health issues	1.72	2.67	1.64
74.	the lack of federal funding for mental health services	1.60	2.33	1.56
73.	the lack of state funding for mental health services	1.50	2.33	1.45
72.	the lack of local funding for mental health services	1.49	2.33	1.44
	Cluster Average	***1.89***	***2.55***	***1.85***
	Standard Deviations	***0.25***	***0.46***	***0.28***

Pattern Matching

Pattern matches offer a graphical representation of rating comparisons between participant groups. The comparisons are based on Pearson's *r*, a descriptive statistic that indicates the presence, strength, and direction of a relationship between two variables. In the context of Concept Mapping, Pearson's *r* indicates the degree of similarity or consistency between the ratings of two groups. The importance of such information is that it alerts researchers to potential points of consensus and disagreement, allowing for proactive problem solving. Based on his knowledge of the issues and stakeholder groups, as well as observations from the focus group sessions, the author chose to compare the following groups on both of the rating scales:

- Residents of Large and Small Counties
- Employees in Large and Small Counties
- Males and Females
- Direct Care Providers and Supervisors
- Direct Care Providers and Administrators
- Supervisors and Administrators
- Parents and Service Providers
- LMHA and Juvenile Probation
- LMHA and DFPS
- LMHA and School Districts
- Juvenile Probation and DFPS
- Juvenile Probation and School Districts
- DFPS and School Districts

The results of the above comparisons are presented and discussed in the following subsections.

Residents of Large and Small Counties

During previous regional service delivery projects and studies, counties with smaller populations, i.e., Houston, Jasper, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler, have raised concerns that counties with larger

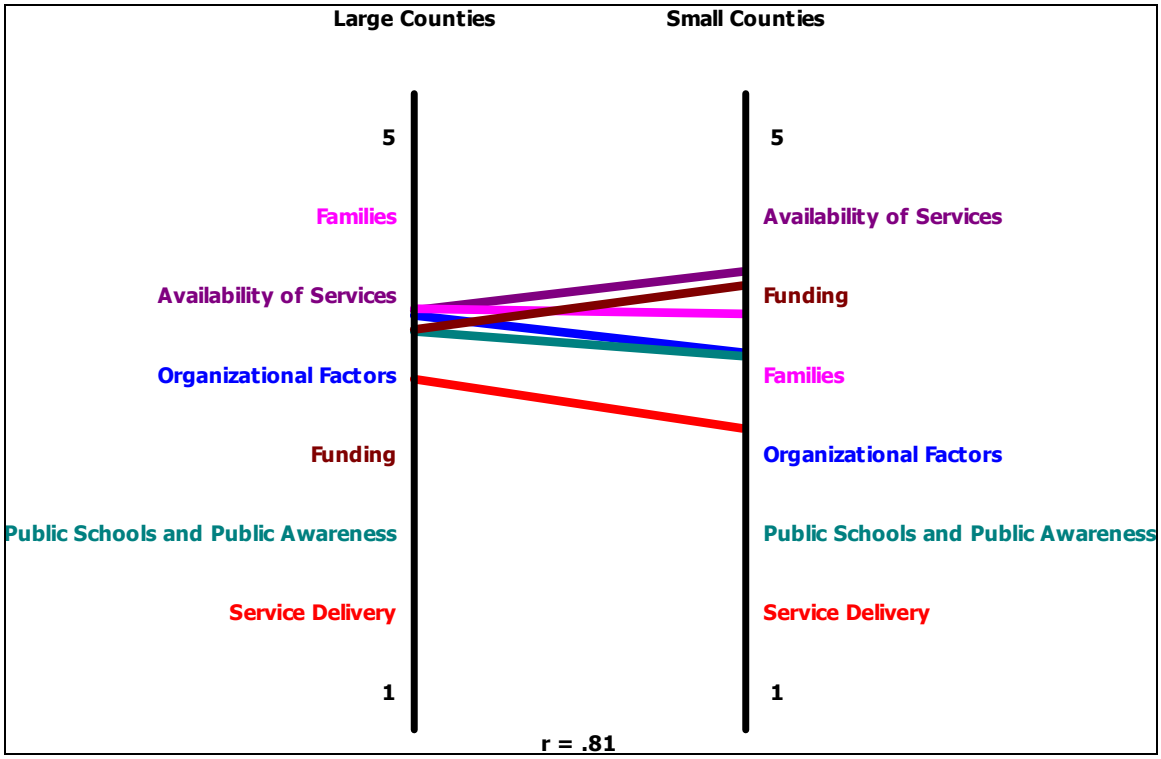
populations (Angelina and Nacogdoches) would dominate decisions and resources (Cooper & Avant, 2006). Since the demographic data collected included both county of residence and county of employment, the author decided to compare the counties with larger populations to those with smaller populations. The first comparison was based on county of residency. Whereas the large and small counties differ in their ranking of the clusters (most frequent to least frequent), overall the average scores were fairly similar (see Table 40). In fact, the greatest difference between groups for the average cluster ratings was 0.35. Furthermore, the standard deviations indicate agreement within groups.

Table 40: Residents of Large and Small Counties- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Large Counties (n = 24)	*x*	3.23	3.72	3.68	3.57	3.74	3.59
	sd	0.37	0.22	0.41	0.25	0.17	0.28
Small Counties (n = 18)	*x*	2.88	4.00	3.42	3.39	3.70	3.90
	sd	0.41	0.15	0.44	0.48	0.30	0.32

The above results are further supported by the pattern match presented in Figure 13. The pattern displays the order in which each group ranked the cluster (highest rating at the top and lowest rating at the bottom). Given this, the pattern match indicates that the two groups disagreed about the overall rank order of the clusters. However, they did agree about which two clusters were the least frequent. Although the pattern match does not display the actual average for each cluster (see Table 40), the averages are represented by points on the two uprights of the ladder graph. For all of the pattern matches in this report the uprights represent a range of scores from 1 to 5. The lines between the two uprights indicate the cluster rankings for the two groups. The line colors correspond to the font colors of the cluster name (e.g., the red line represents Service Delivery). Finally, the correlation coefficient (*r*) is included below the ladder graph. An *r* of .81 indicates a very strong direct relationship between the scores of the two groups. Specifically, the two groups' ratings are very consistent or similar and move in the same direction (clusters ranked high by one group were ranked high by the other group).

Figure 13: Residents of Large and Small Counties- Frequency

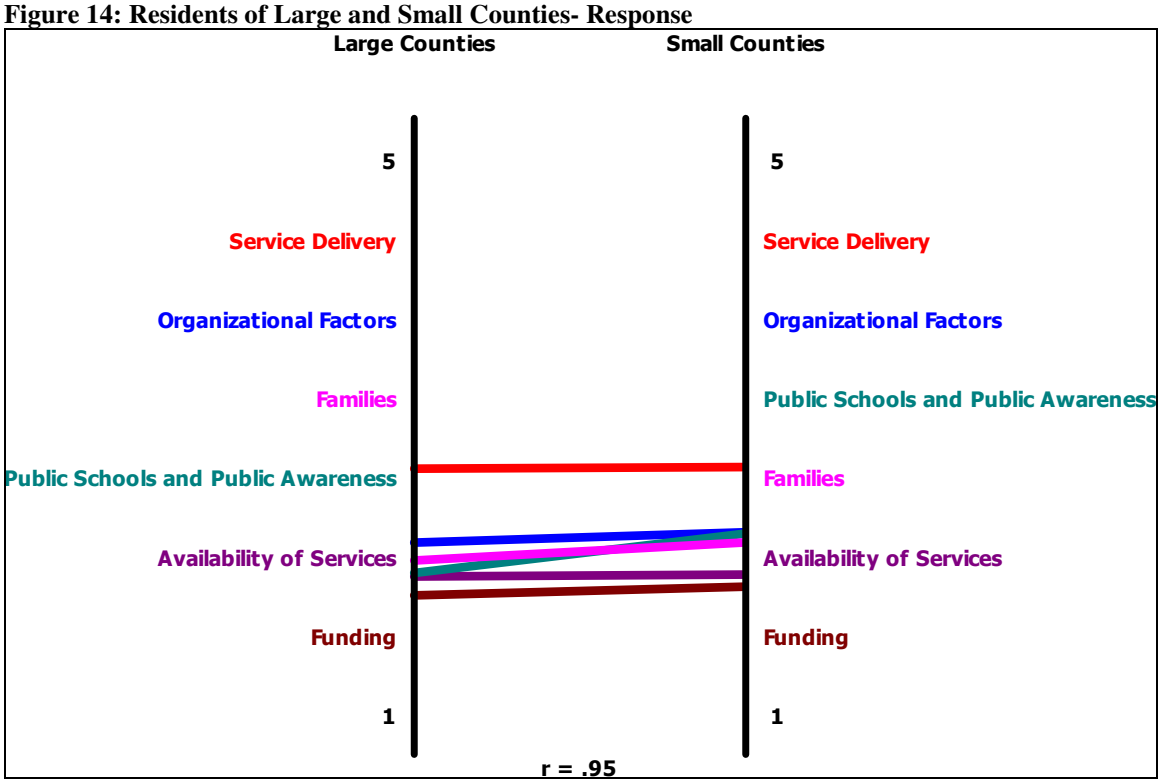


The results of the comparison of response scores for county of residency are presented in Table 41 and Figure 14. In this comparison, the two groups ranked the clusters in a very similar order. The only difference being that residents of large counties ranked Families third and Public Schools and Public Awareness fourth and residences of small counties ranked Public Schools and Public Awareness third and Families fourth. Furthermore, the average group scores for each cluster were very similar and the standard deviations indicate consistency within the groups. The similarities between the two groups are further demonstrated by an *r* of .95. Thus, the results suggest that the groups responded to the statements in a similar manner.

Table 41: Residents of Large and Small Counties- Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Large Counties (n = 24)	*x*	2.75	1.99	2.23	2.01	2.10	1.85
	sd	0.74	0.24	0.62	0.28	0.40	0.27
Small Counties (n = 17)	*x*	2.77	2.00	2.31	2.29	2.22	1.91
	sd	0.53	0.22	0.41	0.32	0.40	0.29

Figure 14: Residents of Large and Small Counties- Response



Employees in Large and Small Counties

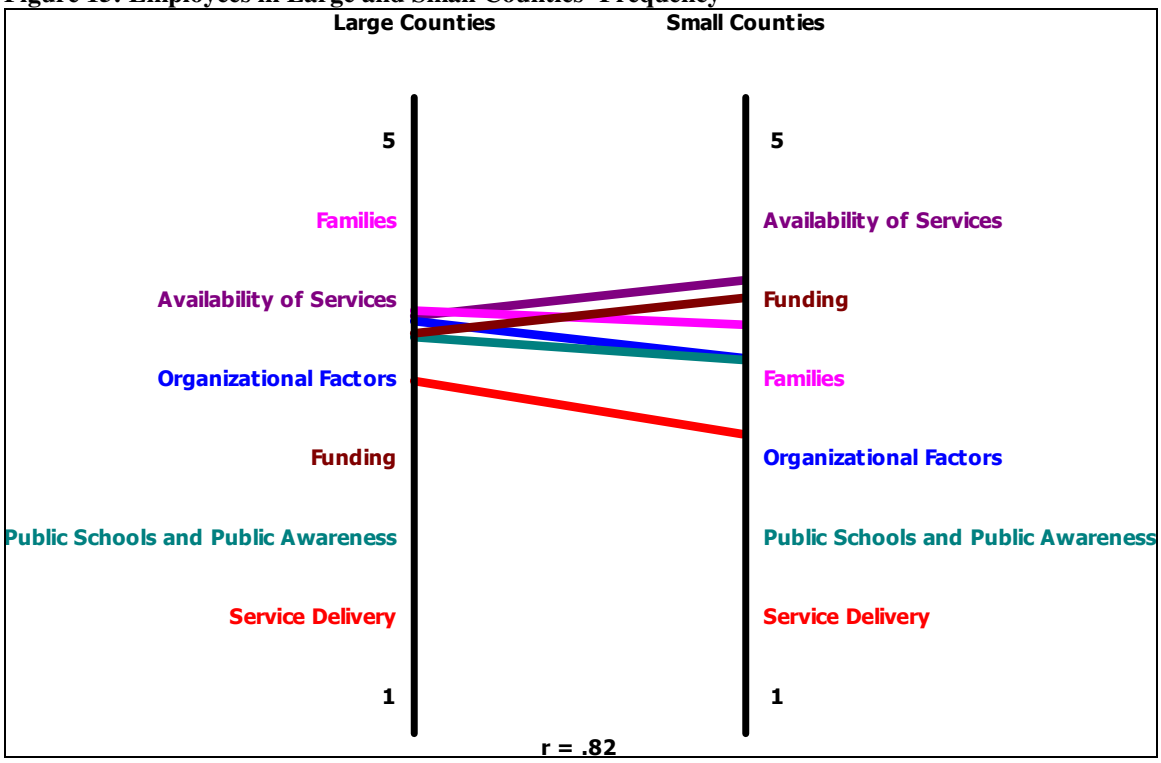
Since some of the participants were employed in a county other than their county of residence, large and small county comparisons were also made based on county of employment. Although the two groups varied in their ranking of the top four clusters for frequency (Figure 16), the average cluster scores were fairly similar as indicated by a maximum difference in average scores of .38 points (Table 42). The standard deviation

scores for each cluster indicate agreement within the groups. As indicated by an *r* of .82, the two groups had very high degree of agreement.

Table 42: Employees in Large and Small Counties- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Large Counties (n = 24)	*x*	3.24	3.71	3.67	3.56	3.74	3.59
	sd	0.35	0.24	0.42	0.25	0.18	0.29
Small Counties (n = 19)	*x*	2.86	3.96	3.41	3.39	3.64	3.84
	sd	0.45	0.17	0.42	0.47	0.29	0.31

Figure 15: Employees in Large and Small Counties- Frequency



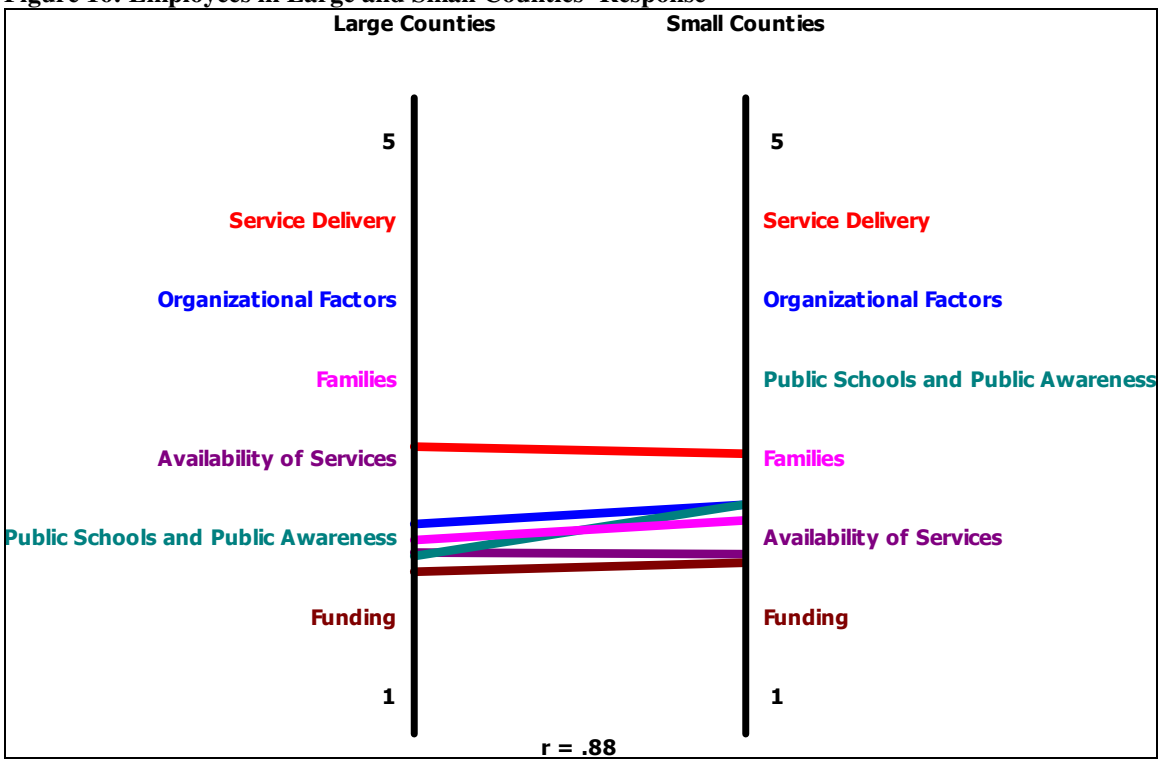
As for response, both groups ranked service delivery as the most positive and funding as the least positive. However, they varied on their ranking of the middle four categories (Figure 16). Despite the differences in cluster rankings, their average cluster scores were similar, as indicated by a maximum difference of .37 points (Table 43). The standard deviation scores for each cluster indicate agreement within groups. Finally, the

pattern match indicates a very high degree of agreement between the groups for the response ratings (r = .88). Overall, the results for frequency and response suggest the potential for agreement between the large and small counties.

Table 43: Employees in Large and Small Counties- Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Large Counties (n = 24)	*x*	2.77	2.01	2.22	1.99	2.10	1.87
	sd	0.78	0.25	0.62	0.30	0.42	0.29
Small Counties (n = 18)	*x*	2.72	2.00	2.35	2.36	2.24	1.94
	sd	0.43	0.19	0.35	0.31	0.33	0.25

Figure 16: Employees in Large and Small Counties- Response



Males and Females

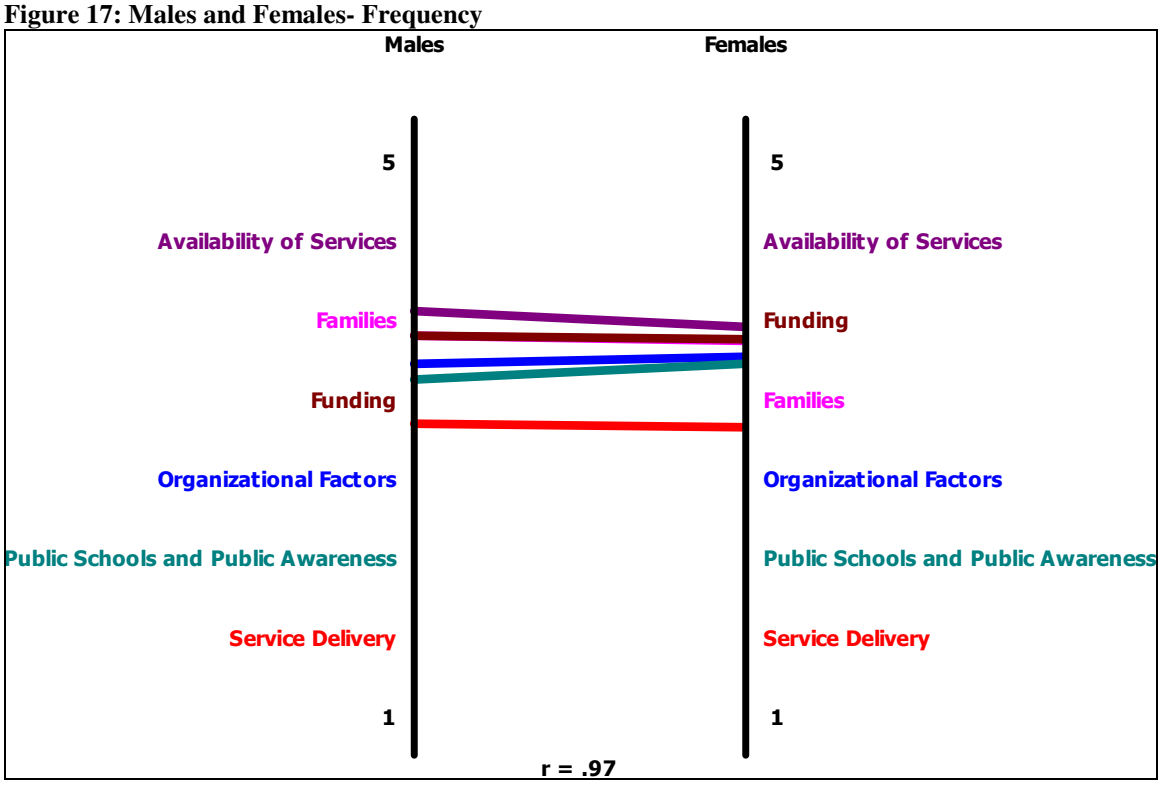
The perceptions of males and females were compared on both of the rating scales. When comparing the two groups, the rank order of the clusters was very similar. In fact, the only difference was the ranking of Families and Funding (Figure 17). The groups

were also similar in their average rankings for each cluster, as indicated by a maximum difference of .12 points (Table 44). These results are consistent with the very high degree of agreement suggested by the pattern match (r = .97).

Table 44: Males and Females- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Males (n = 12)	*x*	3.09	3.89	3.52	3.40	3.72	3.73
	sd	0.51	0.25	0.43	0.36	0.24	0.29
Females (n = 31)	*x*	3.06	3.79	3.57	3.52	3.69	3.69
	sd	0.35	0.16	0.43	0.34	0.22	0.32

Figure 17: Males and Females- Frequency



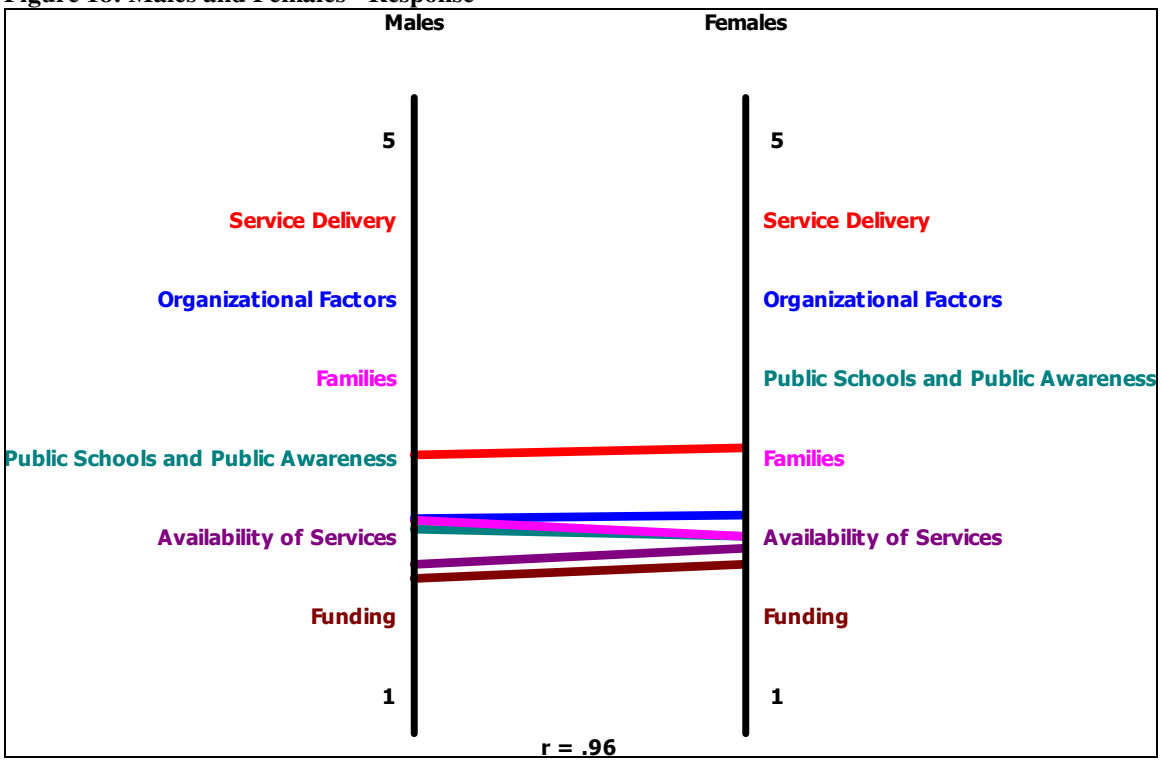
In terms of response, males and females rated and ranked the clusters in a similar manner (Table 45 and Figure 18). The maximum difference between groups for average cluster ratings was .12 points and the only difference in ranking was for third and fourth

place. Specifically, males ranked Families third and Public Schools and Public Awareness fourth, while females reversed this order. These differences had a limited impact on the overall degree of agreement between the groups (r = .96). In terms of agreement within groups, the standard deviation scores for each cluster suggest a fair amount of agreement. In general, the results for frequency and response suggest a strong potential for agreement between male and female respondents.

Table 45: Males and Females - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Males (n = 12)	*x*	2.71	1.92	2.25	2.18	2.24	1.83
	sd	0.61	0.22	0.47	0.29	0.47	0.32
Females (n = 30)	*x*	2.77	2.04	2.28	2.13	2.13	1.93
	sd	0.64	0.23	0.52	0.27	0.35	0.28

Figure 18: Males and Females - Response



Direct Care Providers and Supervisors

Given that opinions often differ among the various hierarchical layers of organizations, comparisons were made among direct care providers, supervisors, and administrators. The first set of comparisons made was between direct care providers and supervisors. The two groups ranked the clusters in the same order and their average ratings were similar as evidenced by a maximum difference of .25 points (Table 46 and Figure 19). These results are consistent with the very high degree of agreement suggested by the pattern match (r = .95). The responses within groups were also consistent as indicated by the standard deviation scores.

As for the response ratings, the average cluster ratings were similar as indicated by a maximum difference of .15 points (Table 47). Direct care providers and supervisors also ranked the clusters in a similar order, with the only difference being the third and fourth clusters (Figure 20). Specifically, direct care staff ranked Families third and Public Schools and Public Awareness fourth, whereas supervisors reversed the ranking for the same clusters. However, the differences in ranking had little affect on the overall agreement between the groups (r = .99). In terms of agreement within groups, the standard deviation scores for each cluster suggest agreement. Although the results for frequency and response suggest a strong potential for agreement between direct care staff and supervisors, one should be cautious when interpreting the results due to the small number of supervisors (n = 7).

Table 46: Direct Care Providers and Supervisors- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Direct Care (n = 29)	*x*	3.11	3.80	3.61	3.52	3.70	3.70
	sd	0.38	0.21	0.41	0.31	0.21	0.27
Supervisors (n = 7)	*x*	3.08	3.55	3.46	3.23	3.48	3.49
	sd	0.44	0.41	0.42	0.39	0.19	0.44

Figure 19: Direct Care Providers and Supervisors - Frequency

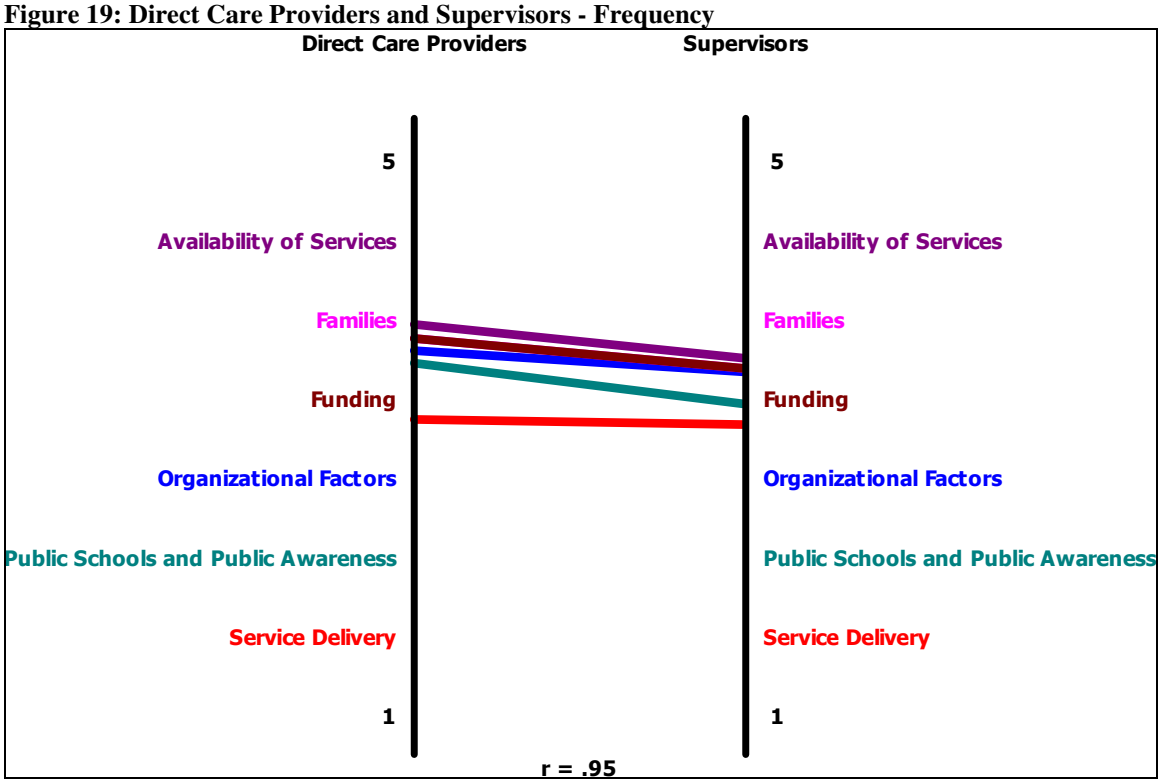
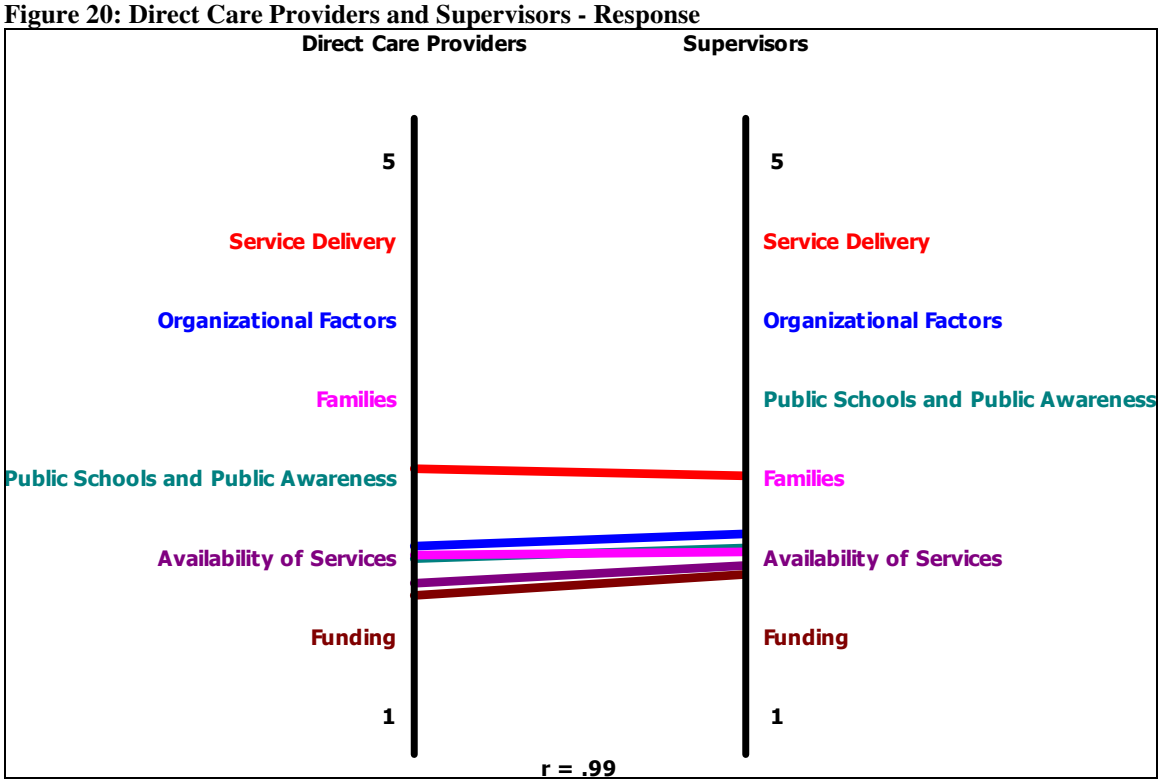


Table 47: Direct Care Providers and Supervisors - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Direct Care (n = 28)	*x*	2.76	1.93	2.20	2.12	2.14	1.85
	sd	0.69	0.26	0.55	0.25	0.38	0.30
Supervisors (n = 7)	*x*	2.71	2.06	2.30	2.19	2.16	2.00
	sd	0.59	0.27	0.52	0.39	0.48	0.36

Figure 20: Direct Care Providers and Supervisors - Response



Direct Care Providers and Administrators

The second set of comparisons related to organizational hierarchy was between direct care providers and administrators. The two groups ranked the clusters in a similar order, the only difference being a reversal of the second and third clusters (Figure 21). Their average ratings were also similar as indicated by a maximum difference of .36 points (Table 48). These results are consistent with the very high degree of agreement suggested by the pattern match (r = .96). The responses within groups were also consistent as indicated by the standard deviation scores.

In terms of response, direct care providers and administrators ranked the clusters in the same order and the maximum difference in cluster averages was .31 points (Table 49 and Figure 22). The pattern match indicated a very high level of agreement (r = -.97). The responses within groups were also consistent as indicated by the standard deviation scores. While the results for frequency and response suggest a strong potential for

agreement between direct care staff and administrators, one should be cautious when interpreting the results due to the small number of administrators (n = 4).

Table 48: Direct Care Providers and Administrators- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Direct Care (n = 29)	*x*	3.11	3.80	3.61	3.52	3.70	3.70
	sd	0.38	0.21	0.41	0.31	0.21	0.27
Administrators (n = 4)	*x*	3.19	4.16	3.67	3.63	3.96	4.07
	sd	0.65	0.37	0.43	0.55	0.31	0.34

Figure 21: Direct Care Providers and Administrators - Frequency

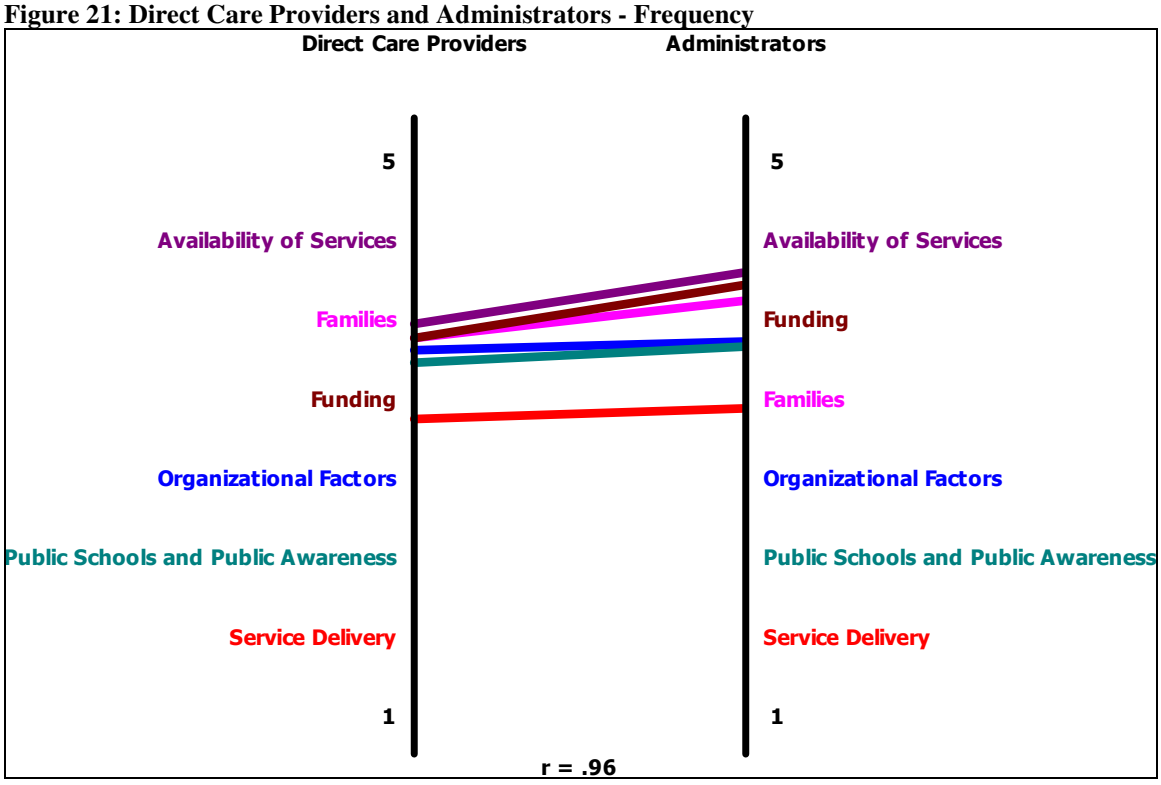
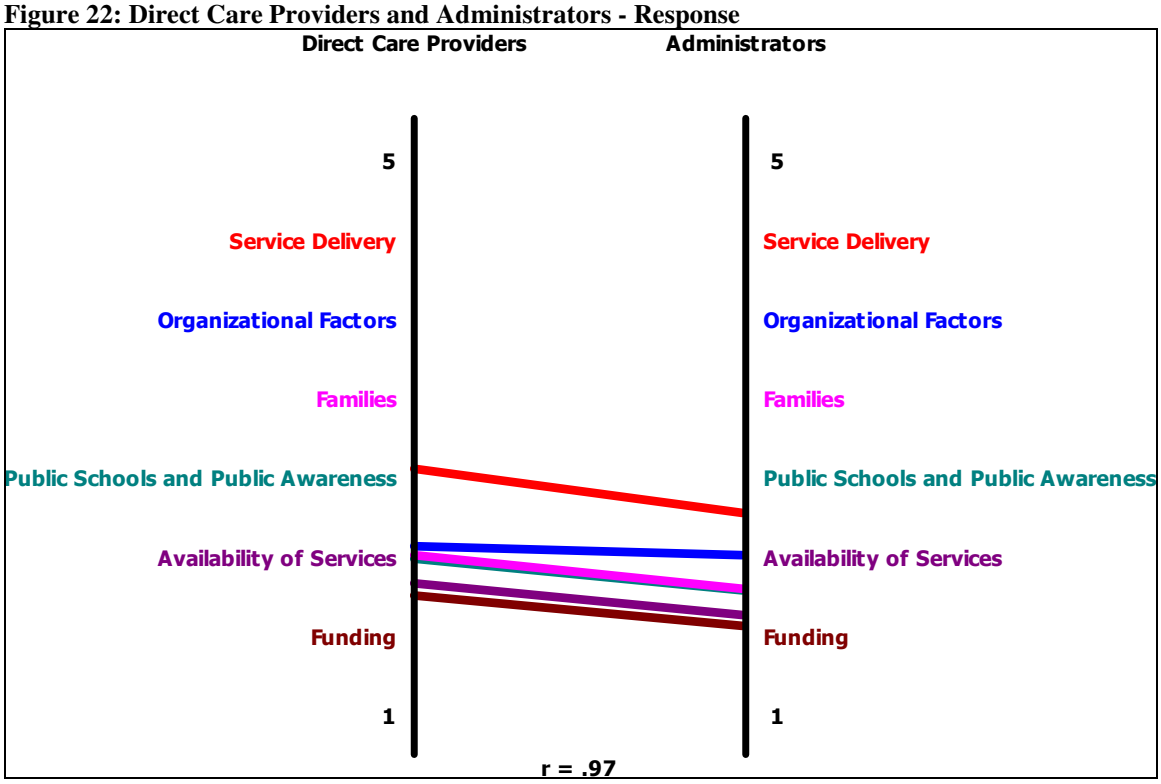


Table 49: Direct Care Providers and Administrators - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Direct Care (n = 28)	*x*	2.76	1.93	2.20	2.12	2.14	1.85
	sd	0.69	0.26	0.55	0.25	0.38	0.30
Administrators (n = 4)	*x*	2.45	1.71	2.13	1.88	1.90	1.63
	sd	0.76	0.32	0.48	0.30	0.36	0.24

Figure 22: Direct Care Providers and Administrators - Response



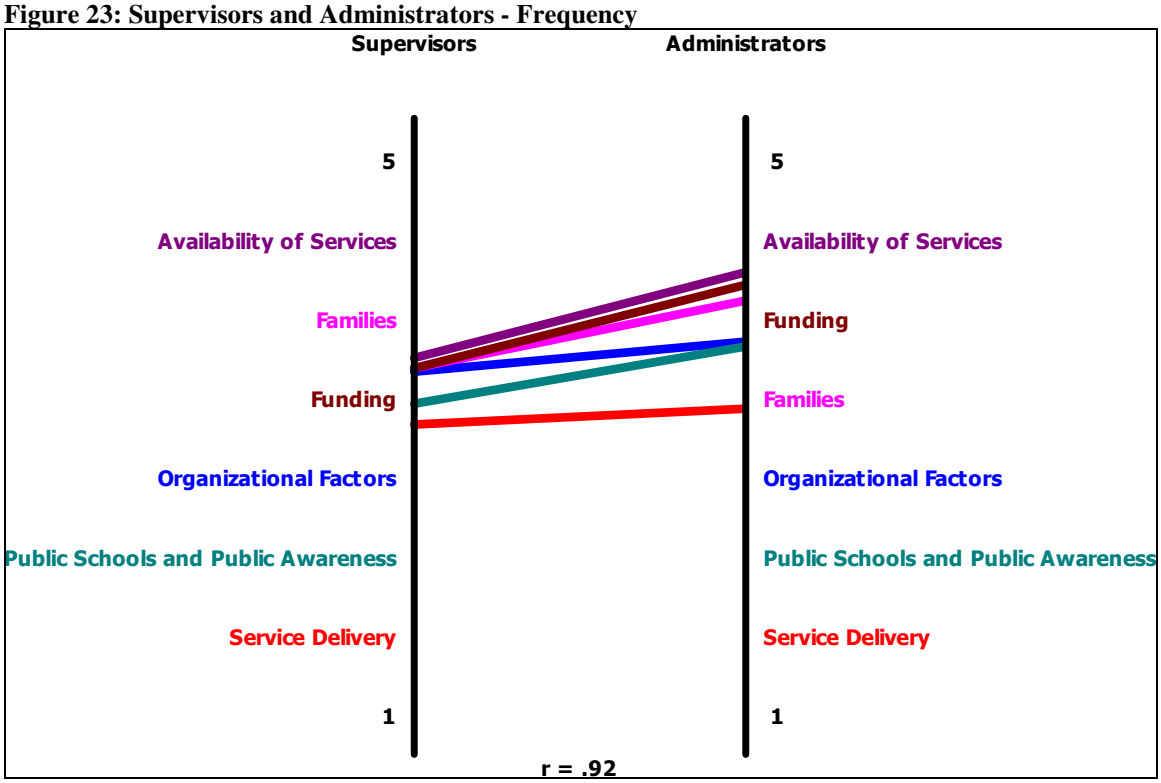
Supervisors and Administrators

The last set of comparisons related to organizational hierarchy was between supervisors and administrators. The two groups ranked the clusters in a similar order, the only difference being a reversal of the second and third clusters (Figure 23). Their average ratings were also similar as indicated by a maximum difference of .58 points (Table 50). It is also interesting that administrators rated each of the clusters higher than supervisors. These results are consistent with the very high degree of agreement suggested by the pattern match (r = .92). The responses within groups were also consistent as indicated by the standard deviation scores.

Table 50: Supervisors and Administrators- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Supervisors (n = 7)	*x*	3.08	3.55	3.46	3.23	3.48	3.49
	sd	0.44	0.41	0.42	0.39	0.19	0.44
Administrators (n = 4)	*x*	3.19	4.16	3.67	3.63	3.96	4.07
	sd	0.65	0.37	0.43	0.55	0.31	0.34

Figure 23: Supervisors and Administrators - Frequency



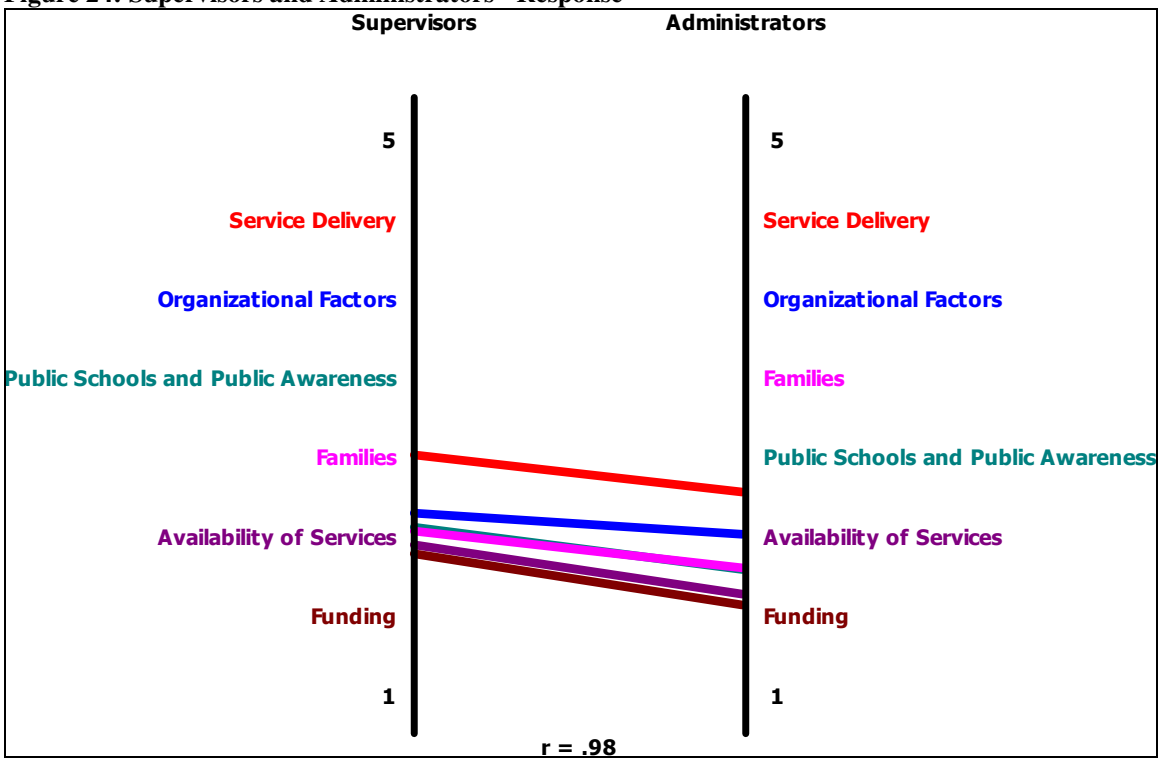
As for the response ratings, supervisors and administrators ranked the clusters in a similar order, with the only difference being in the third and fourth clusters (Figure 24). Although supervisors were more positive in their responses, the average ratings were very similar as indicated by a maximum difference of .37 points (Table 51). The degree of agreement for response was also very high (r = .98). The responses within groups were consistent as indicated by the standard deviation scores. Even though the results for frequency and response suggest a strong potential for agreement between supervisors and

administrators, one should be cautious when interpreting the results due to the small number of supervisors (n = 4) and administrators (n = 7).

Table 51: Supervisors and Administrators - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Supervisors (n = 7)	*x*	2.71	2.06	2.30	2.19	2.16	2.00
	sd	0.59	0.27	0.52	0.39	0.48	0.36
Administrators (n = 4)	*x*	2.45	1.71	2.13	1.88	1.90	1.63
	sd	0.76	0.32	0.48	0.30	0.36	0.24

Figure 24: Supervisors and Administrators - Response



Parents and Service Providers

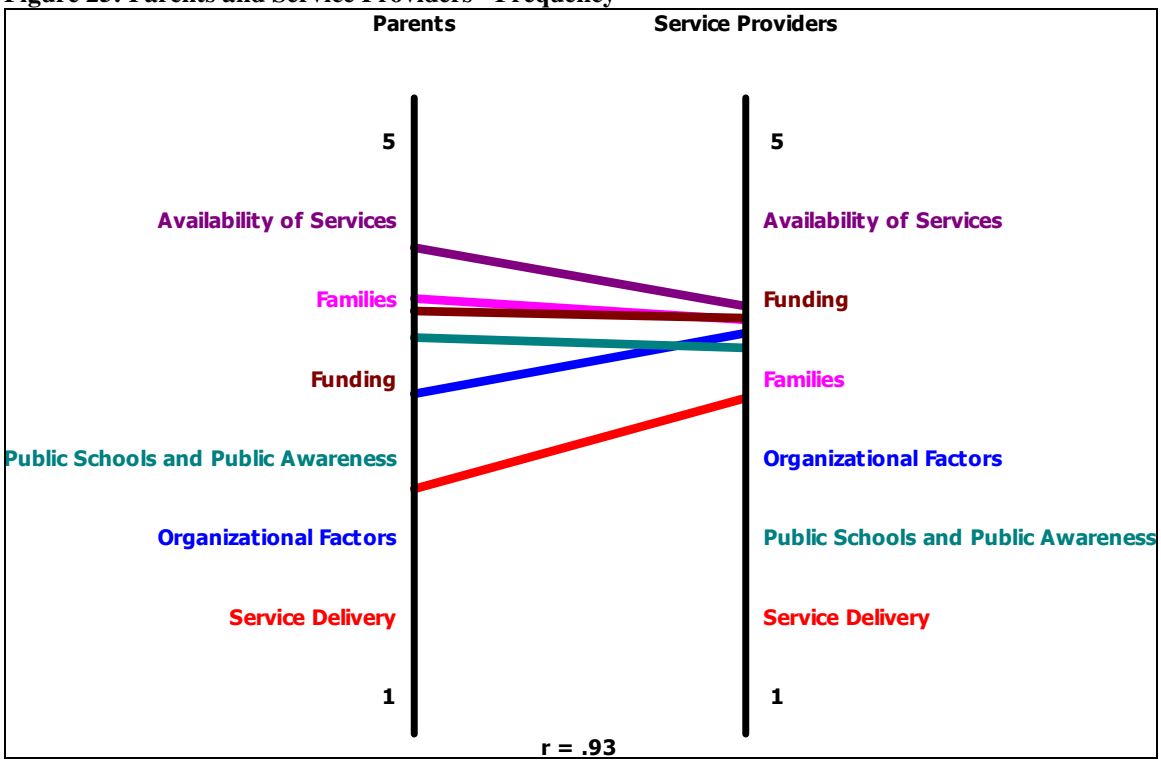
Comparisons were also made between parents and service providers. In terms of cluster rankings, the two groups only agreed on the first and last clusters (Figure 25). However, their average cluster ratings were similar, as indicated by a maximum difference of .64 points (Table 52). Despite the differences in cluster rankings, the

pattern match suggested a very high degree of agreement (r = .93). Overall, the responses within groups tended to be consistent as indicated by the standard deviation scores. It should be noted that the standard deviation scores suggest more variance among the parents' response, which is most likely due to the small number (n = 3).

Table 52: Parents and Service Providers- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Parents (n = 3)	*x*	2.47	4.20	3.15	3.56	3.83	3.75
	sd	0.57	0.52	0.86	0.63	0.57	0.68
Service Providers (n = 40)	*x*	3.11	3.79	3.59	3.48	3.69	3.70
	sd	0.38	0.17	0.38	0.32	0.18	0.27

Figure 25: Parents and Service Providers - Frequency



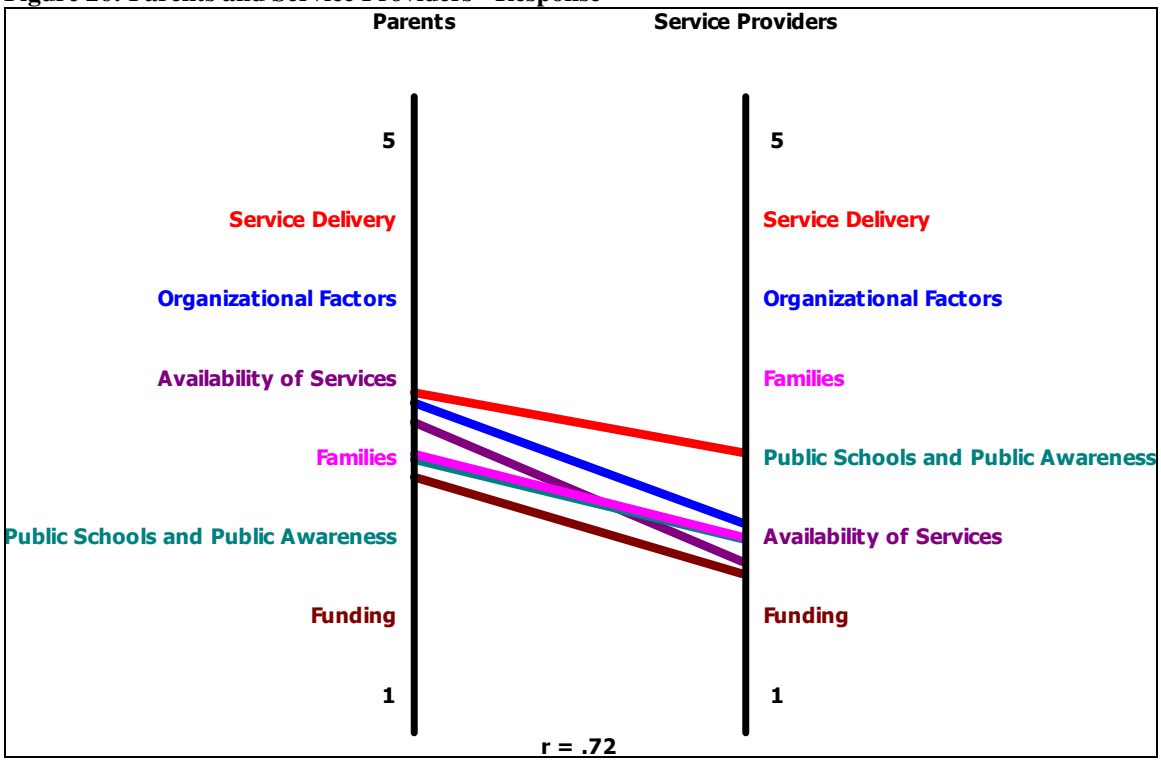
Parents and service providers agreed on the first, second, and sixth clusters (Figure 26). There were some differences in the average cluster scores, as evidenced by differences ranging from .43 points to 1.01 points (Table 53). The largest differences

were for Availability of Services (1.01 points), Organizational Factors (.87 points), and Funding (.70 points). Specifically, parents' responses were closer to neutral and service providers were more discouraged. These results are consistent with the comments parents made during the focus groups, which indicated overall their experiences with service delivery had been positive. Despite these differences, the pattern match suggests a high degree of agreement between the responses of the two groups (r = .72). Overall, the results for frequency and response suggest a strong potential for agreement between parents and service providers. However, one should be cautious when interpreting the results due to the small number of parents (n = 3).

Table 53: Parents and Service Providers - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Parents (n = 3)	*x*	3.15	2.94	3.08	2.67	2.71	2.55
	sd	0.42	0.40	0.44	0.39	0.50	0.46
Service Providers (n = 39)	*x*	2.72	1.93	2.21	2.11	2.12	1.85
	sd	0.66	0.22	0.52	0.26	0.38	0.28

Figure 26: Parents and Service Providers - Response



LMHA and Juvenile Probation

Due to the tendency of opinions and orientations to vary among organizations and their personnel, comparisons for both of the rating scales were made among the following organizations: Local Mental Health Authority (LMHA), Juvenile Probation, Department of Family and Protective Services (DFPS), and School Districts. The first set of comparisons focused on LMHA and Juvenile probation employees. The two groups ranked the clusters in similar orders with the only disagreement being the fourth and fifth clusters (Figure 27). Their average ratings for the clusters were also similar, with a maximum difference of .27 points (Table 54). These differences had little affect on the pattern match, which suggested a very high degree of agreement (r = .97). The standard deviation scores suggest agreement among respondents within groups.

The cluster rankings for response were similar, the only difference being the third and fourth clusters (Figure 28). The average cluster ratings were also similar as suggested by a maximum difference of .27 points (Table 55). These results are consistent with the very high degree of agreement indicated by the pattern match (r = .97). The standard deviation scores suggest agreement within groups, except for Service Delivery. In general, the results for frequency and response suggest a strong potential for agreement between LMHA and Juvenile probation employees.

Table 54: LMHA and Juvenile Probation- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
LMHA (n = 12)	*x*	3.12	3.76	3.61	3.62	3.74	3.70
	sd	0.47	0.26	0.40	0.41	0.35	0.31
Juv Probation (n = 12)	*x*	3.26	4.02	3.72	3.72	3.99	3.97
	sd	0.48	0.22	0.43	0.35	0.22	0.29

Figure 27: LMHA and Juvenile Probation - Frequency

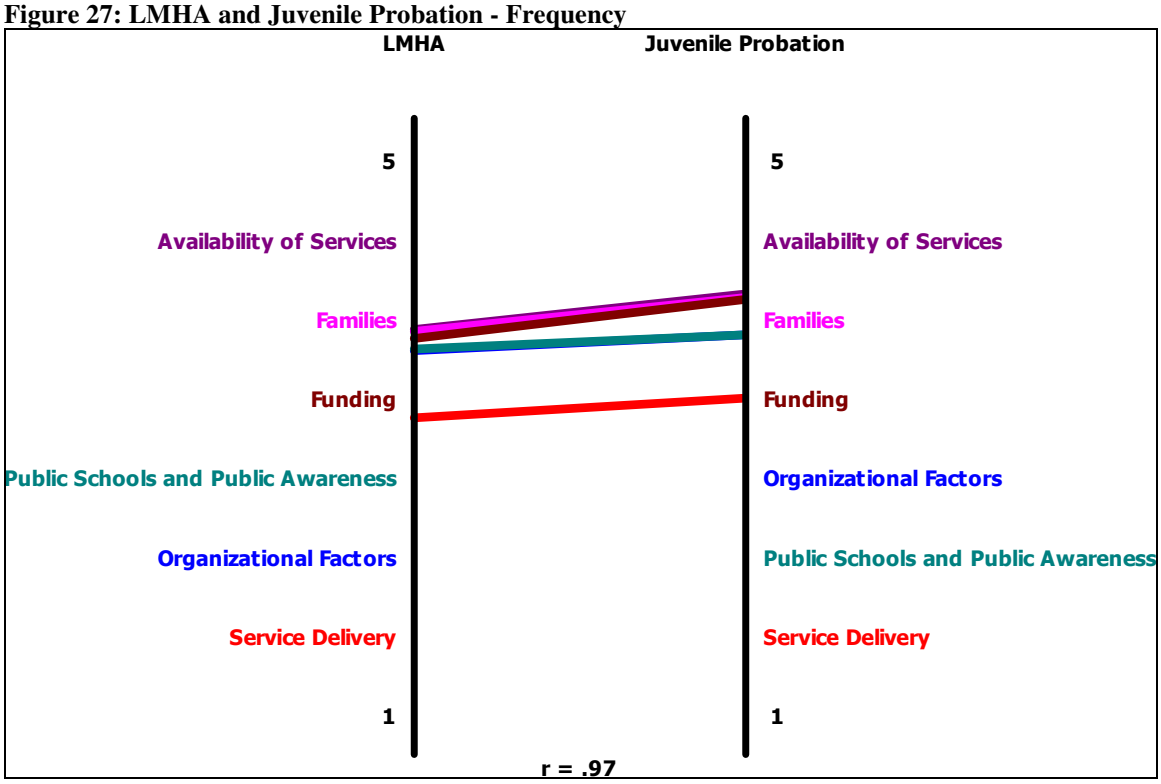
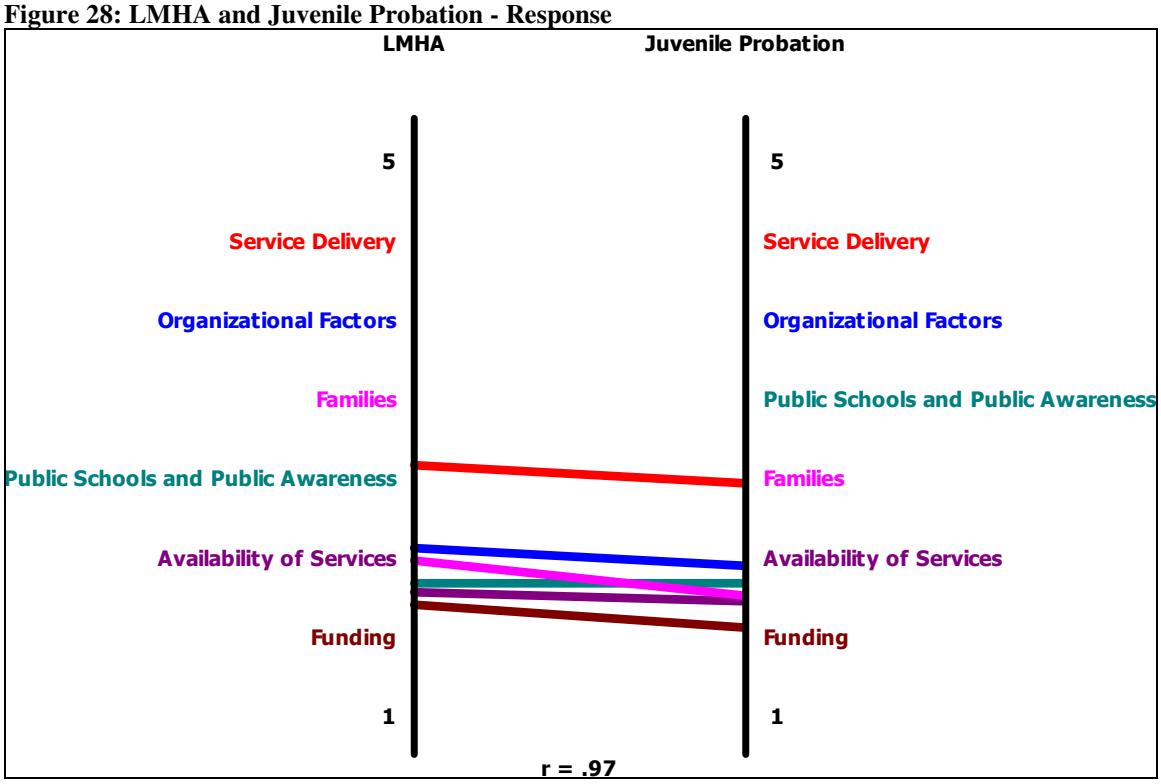


Table 55: LMHA and Juvenile Probation - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
LMHA (n = 12)	*x*	2.78	1.88	2.19	1.94	2.11	1.78
	sd	0.71	0.26	0.65	0.37	0.58	0.36
Juv Probation (n = 12)	*x*	2.66	1.81	2.06	1.94	1.84	1.62
	sd	0.83	0.28	0.60	0.24	0.35	0.29

Figure 28: LMHA and Juvenile Probation - Response



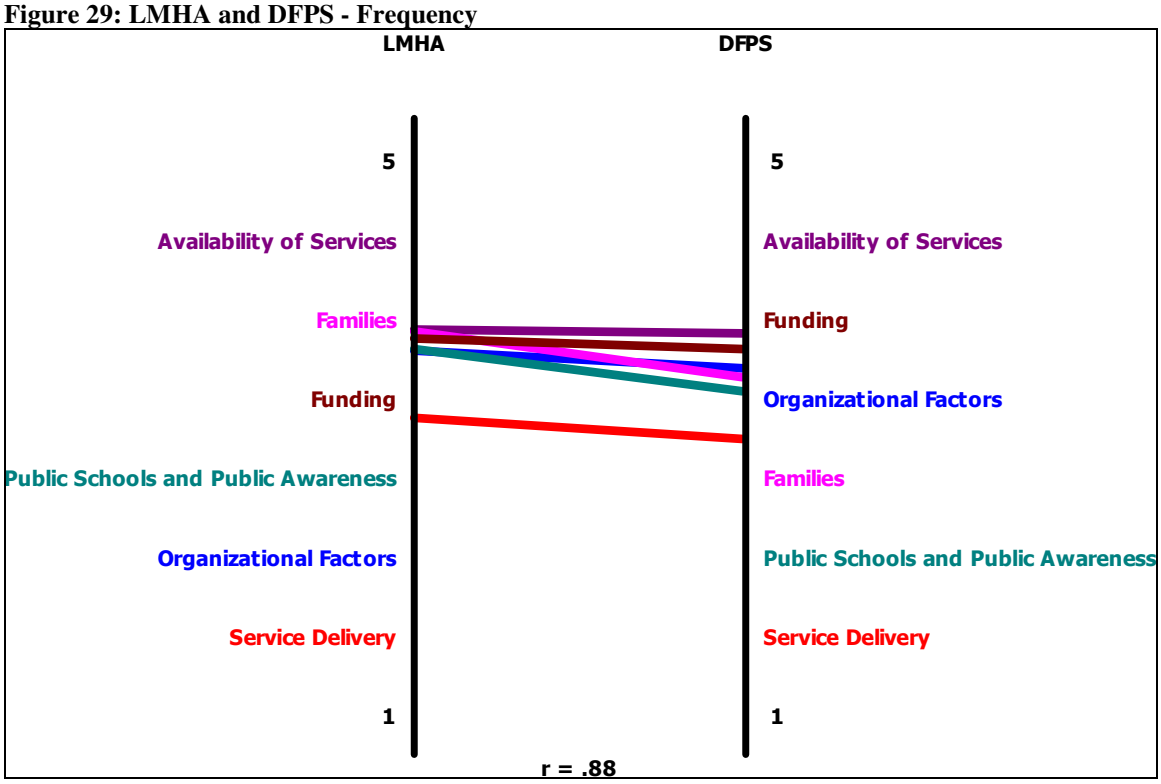
LMHA and DFPS

The second set of professional comparisons focused on employees of the LMHA and DFPS. While the two groups only agreed on the first and sixth cluster, the range for the cluster averages for the second, third, fourth, and fifth clusters was less than .50 points (Table 56 and Figure 29). The average cluster scores for the groups were also similar, the greatest difference being .32 points. These results are consistent with the very high degree of agreement suggested by the pattern match (r = .88). Based on the standard deviation scores, there was agreement among participants within the groups.

Table 56: LMHA and DFPS- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
LMHA (n = 12)	*x*	3.12	3.76	3.61	3.62	3.74	3.70
	sd	0.47	0.26	0.40	0.41	0.35	0.31
DFPS (n = 12)	*x*	2.98	3.74	3.49	3.31	3.42	3.63
	sd	0.34	0.22	0.39	0.37	0.30	0.33

Figure 29: LMHA and DFPS - Frequency

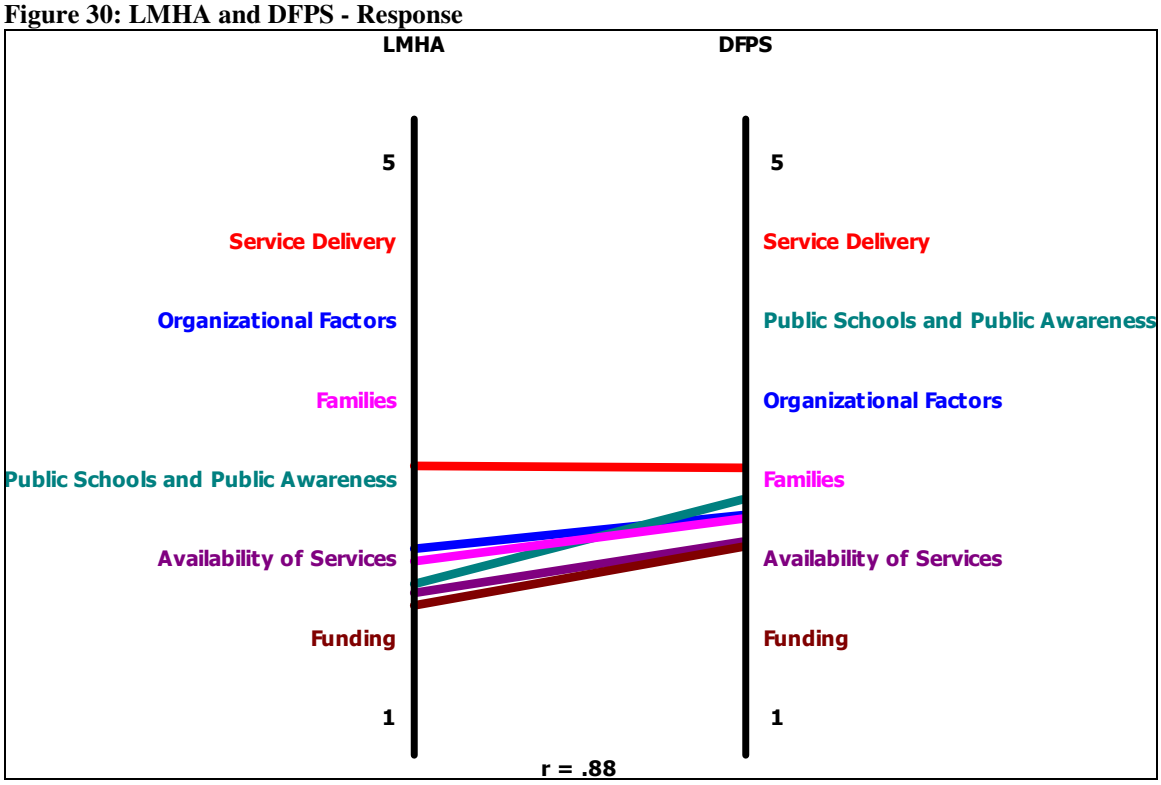


In terms of response, the two groups disagreed on the order of the second, third, and fourth clusters (Figure 30). However, the average cluster scores were similar as indicated by a maximum difference of .60 points (Table 57). It is worth noting that overall DFPS employees were more positive in their responses, but still discouraged. Despite the differences in rankings, the pattern match suggests a very high degree of agreement (r = .90). The standard deviation scores suggest agreement among members within groups, except for LMHA employees' responses for Service Delivery. Overall, the results for frequency and response suggest a strong potential for agreement between LMHA and DFPS employees.

Table 57: LMHA and DFPS - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
LMHA (n = 12)	*x*	2.78	1.88	2.19	1.94	2.11	1.78
	sd	0.71	0.26	0.65	0.37	0.58	0.36
DFPS (n = 11)	*x*	2.78	2.24	2.44	2.54	2.40	2.20
	sd	0.42	0.24	0.31	0.24	0.28	0.26

Figure 30: LMHA and DFPS - Response



LMHA and School Districts

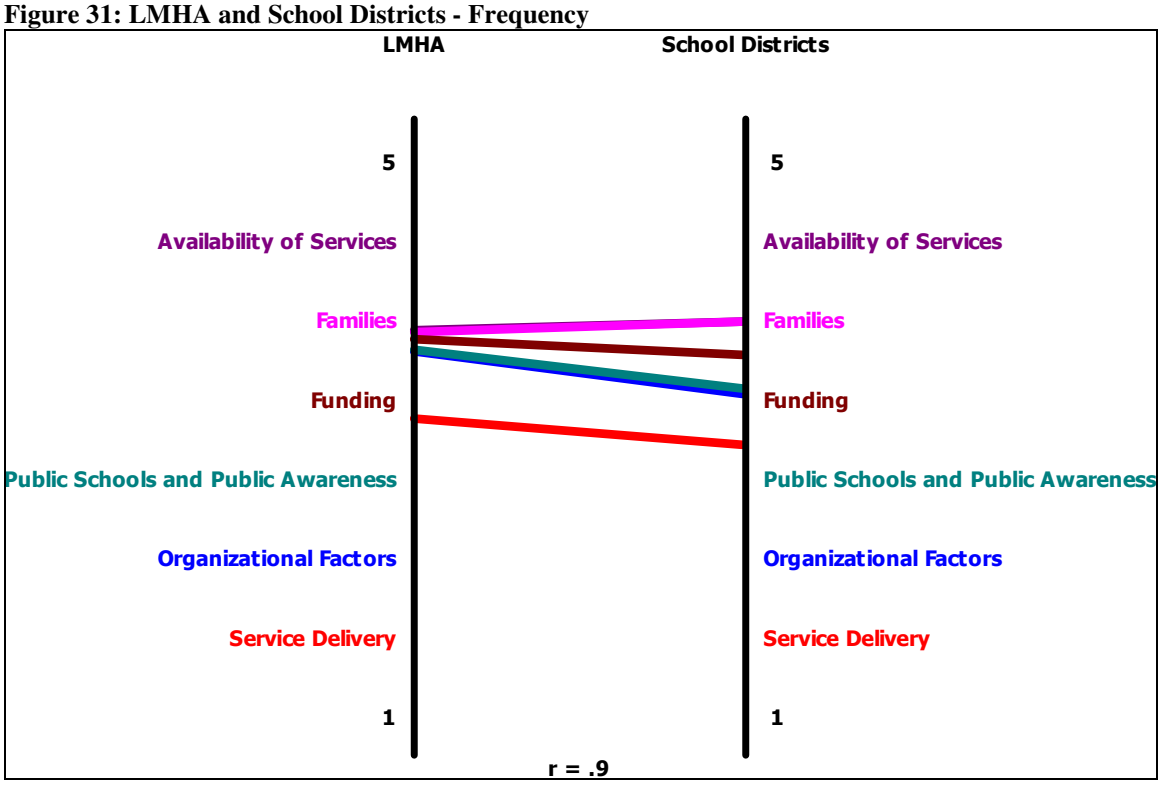
LMHA and school district employees agreed on the cluster rankings (Figure 31) and were fairly consistent in their average ratings for each of the clusters as evidenced by a maximum difference of .30 points (Table 58). The pattern match indicated a very high degree of agreement between the two groups (r = .90). Although the LMHA employees tended to agree on their ratings, the standard deviation scores for the school district employees suggest some disagreement for Service Delivery, Organizational Factors, and

Public Schools and Public Awareness. However, one should be cautions when interpreting these results due to the low number of school district employees (n = 2).

Table 58: LMHA and School Districts- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
LMHA (n = 12)	*x*	3.12	3.76	3.61	3.62	3.74	3.70
	sd	0.47	0.26	0.40	0.41	0.35	0.31
Schools (n = 2)	*x*	2.93	3.83	3.31	3.35	3.82	3.59
	sd	0.70	0.32	0.77	0.69	0.24	0.57

Figure 31: LMHA and School Districts - Frequency



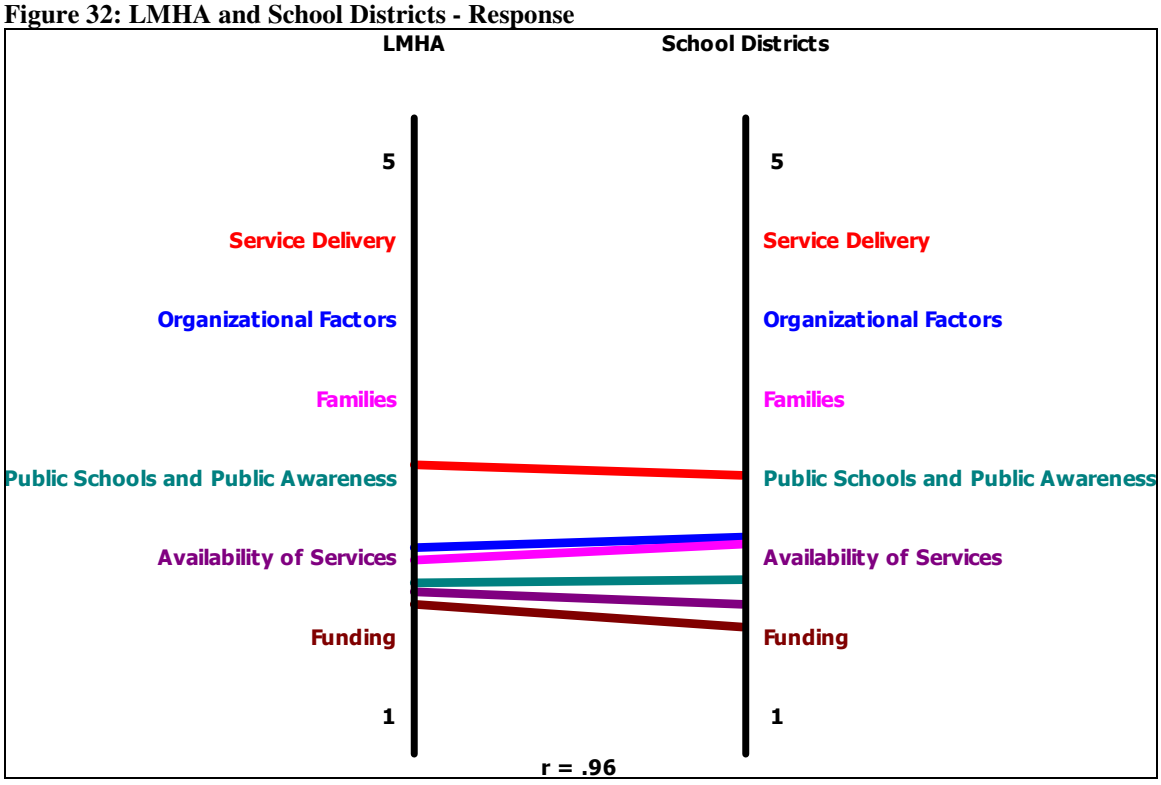
The cluster rankings for response were the same for both groups (Figure 32) and the average cluster ratings were similar as indicated by a maximum difference of .10 points (Table 59). The pattern match for response also indicated a very high degree of agreement between the groups (*r* = .96). LMHA employees were fairly consistent in their

ratings, except for Service Delivery. However, the school district employees differed in their responses for Service Delivery and Organizational Factors. As previously noted, one should be cautious in interpreting these results due to the low number of school district employees (n = 2). The lack of school district employees also prevents the generalization of these results to school district employees within the region.

Table 59: LMHA and School Districts - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
LMHA (n = 12)	*x*	2.78	1.88	2.19	1.94	2.11	1.78
	sd	0.71	0.26	0.65	0.37	0.58	0.36
Schools (n = 2)	*x*	2.71	1.78	2.27	1.96	2.21	1.62
	sd	1.12	0.44	0.75	0.50	0.56	0.36

Figure 32: LMHA and School Districts - Response



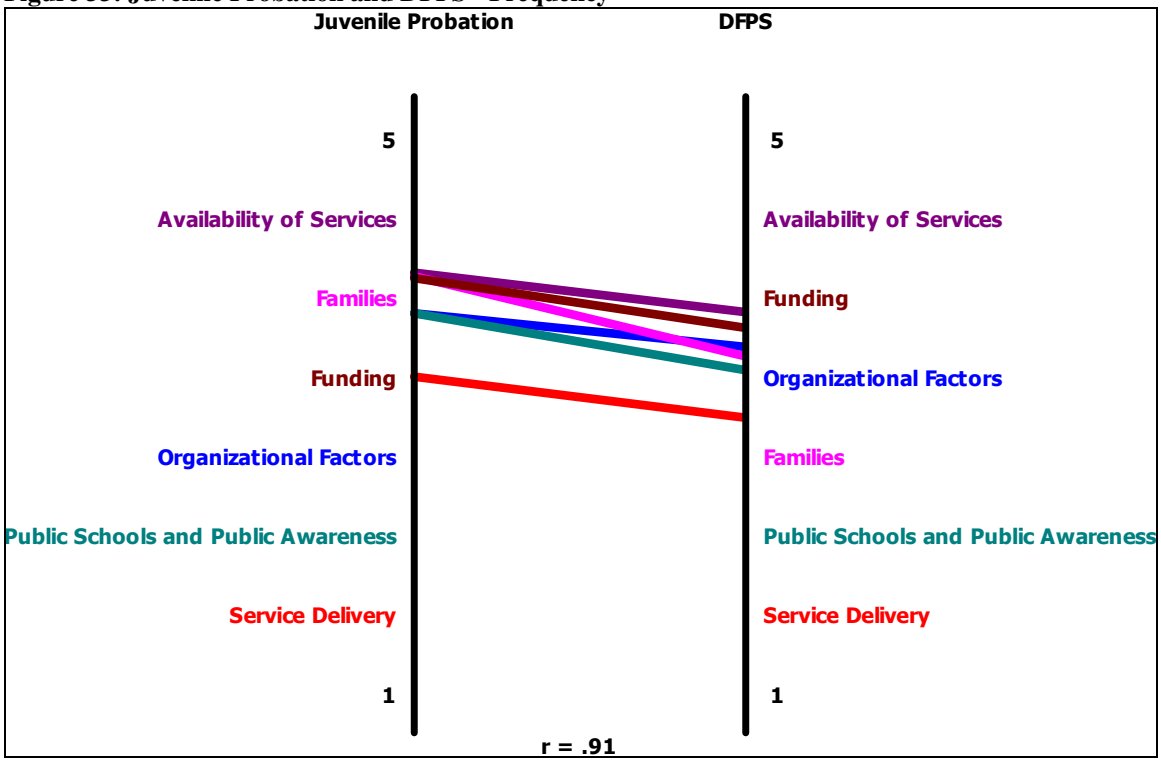
Juvenile Probation and DFPS

Juvenile probation and DFPS employees disagreed on the second, third, and fourth cluster rankings (Figure 33). However, the average cluster ratings for each group were similar as indicated by a maximum difference of .57 points (Table 60). It is interesting that overall the cluster ratings for DFPS employees were lower than those of juvenile probation officers, suggesting that DFPS employees experienced the factors less frequently. The standard deviation scores suggested agreement within the groups and the pattern match indicated a very high degree of consistency between the groups (r = .91).

Table 60: Juvenile Probation and DFPS- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Juv Probation (n = 12)	*x*	3.26	4.02	3.72	3.72	3.99	3.97
	sd	0.48	0.22	0.43	0.35	0.22	0.29
DFPS (n = 12)	*x*	2.98	3.74	3.49	3.31	3.42	3.63
	sd	0.34	0.22	0.39	0.37	0.30	0.33

Figure 33: Juvenile Probation and DFPS - Frequency

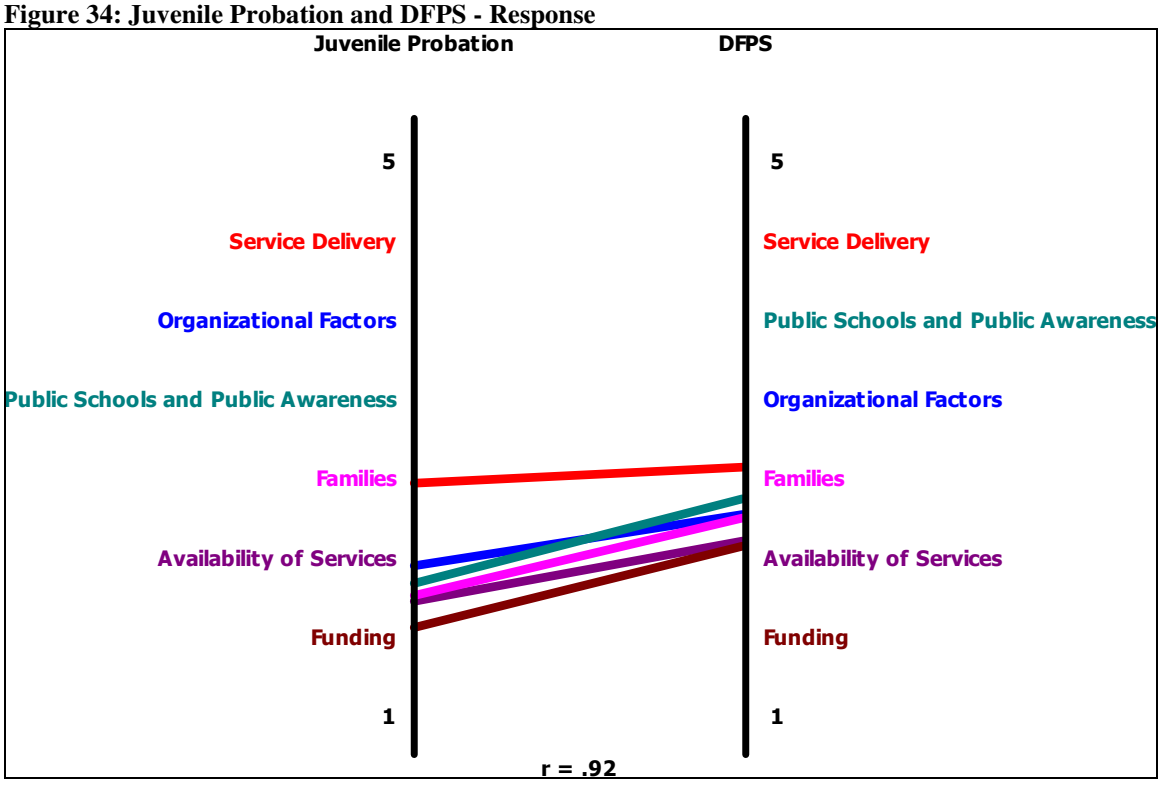


Although juvenile probation and DFPS employees disagreed on the second and third cluster rankings, their average cluster scores were similar as evidenced by a maximum difference of .60 points (Table 61 and Figure 34). Juvenile probation employees were more discouraged by the factors than DFPS workers, which is reasonable given that juvenile probation employees reported experiencing the factors more often than DFPS employees. The standard deviation scores suggested agreement within groups, except for juvenile probation officers, who demonstrated some variance in responses for Service Delivery. The pattern match indicated a very high degree of agreement between the groups (r = .92).

Table 61: Juvenile Probation and DFPS - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Juv Probation (n = 12)	*x*	2.66	1.81	2.06	1.94	1.84	1.62
	sd	0.83	0.28	0.60	0.24	0.35	0.29
DFPS (n = 11)	*x*	2.78	2.24	2.44	2.54	2.40	2.20
	sd	0.42	0.24	0.31	0.24	0.28	0.26

Figure 34: Juvenile Probation and DFPS - Response



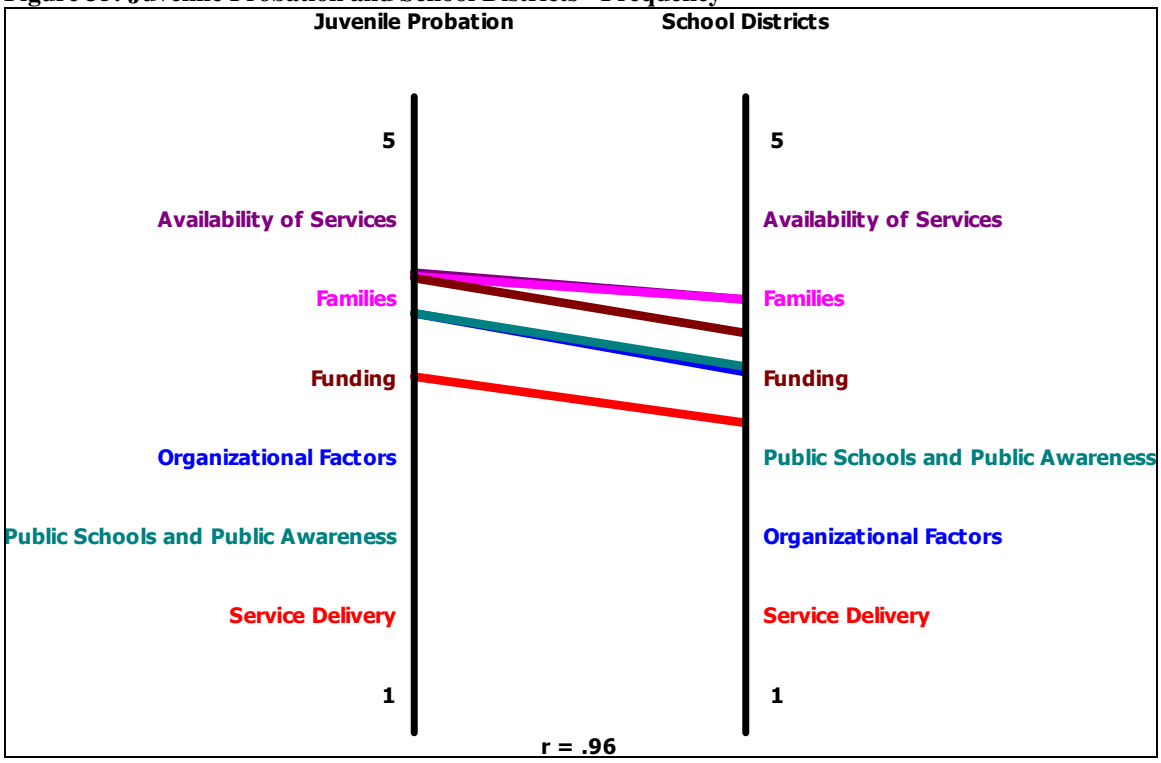
Juvenile Probation and School Districts

Juvenile probation and school district employees disagreed on the fourth and fifth clusters, but their average cluster ratings were similar as evidenced by a maximum difference of .41 points (Table 62 and Figure 35). Whereas juvenile probation employees were fairly consistent in their responses, school district employees varied in their responses for Service Delivery, Organizational Factors, and Public Schools and Public Awareness. As previously noted, these variances may be a result of the low number of participants from school districts (n = 2). The pattern match suggests a very high degree of agreement between the groups (r = .96).

Table 62: Juvenile Probation and School Districts- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Juv Probation (n = 12)	*x*	3.26	4.02	3.72	3.72	3.99	3.97
	sd	0.48	0.22	0.43	0.35	0.22	0.29
Schools (n = 2)	*x*	2.93	3.83	3.31	3.35	3.82	3.59
	sd	0.70	0.32	0.77	0.69	0.24	0.57

Figure 35: Juvenile Probation and School Districts - Frequency

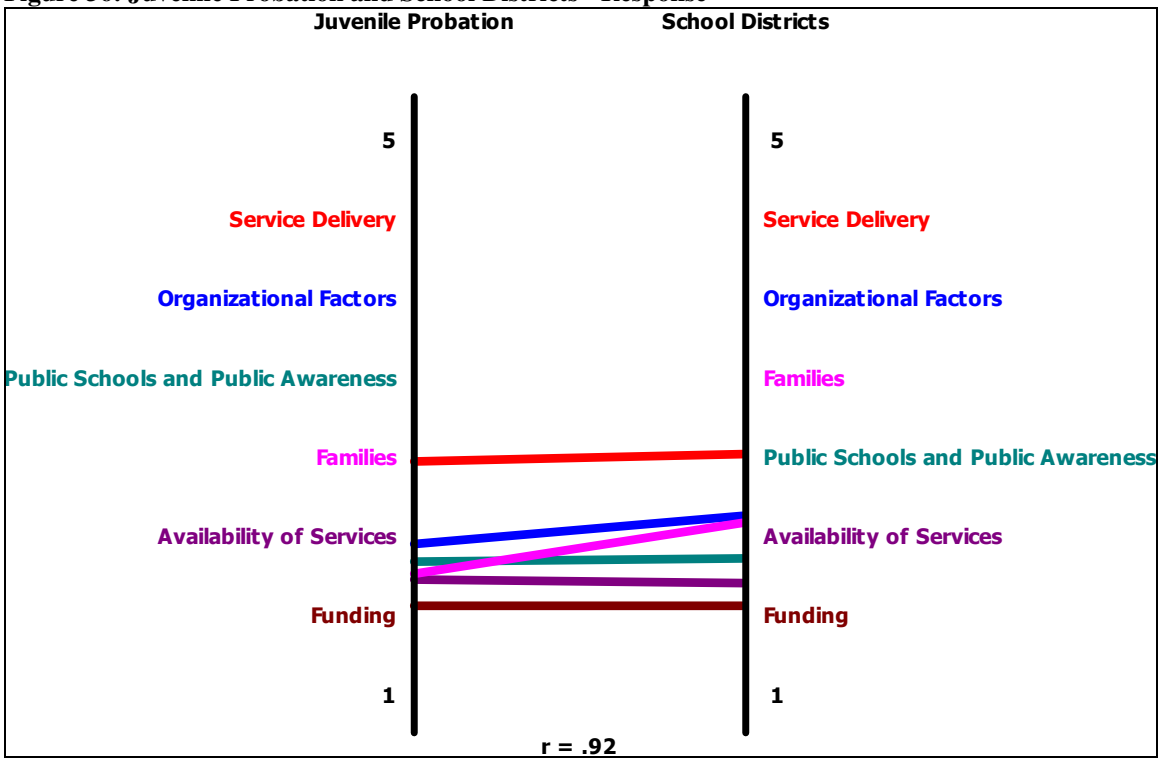


In terms of response to the factors, the two groups disagreed on the second, third, and fourth clusters (Figure 36). However, their average cluster scores were very similar as indicated by a maximum difference of .37 points (Table 63). Juvenile probation officers were consistent in their responses. However, the school district employees varied in their responses for Service Delivery and Organizational Factors. The pattern match suggests a very high degree of consistency between the groups (r = .92). As previously noted, one should be cautious in interpreting these results due to the low number of school district employees (n = 2). Also, the lack of school district employees prevents the generalization of these results to school district employees within the region.

Table 63: Juvenile Probation and School Districts - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
Juv Probation (n = 12)	*x*	2.66	1.81	2.06	1.94	1.84	1.62
	sd	0.83	0.28	0.60	0.24	0.35	0.29
Schools (n = 2)	*x*	2.71	1.78	2.27	1.96	2.21	1.62
	sd	1.12	0.44	0.75	0.50	0.56	0.36

Figure 36: Juvenile Probation and School Districts - Response



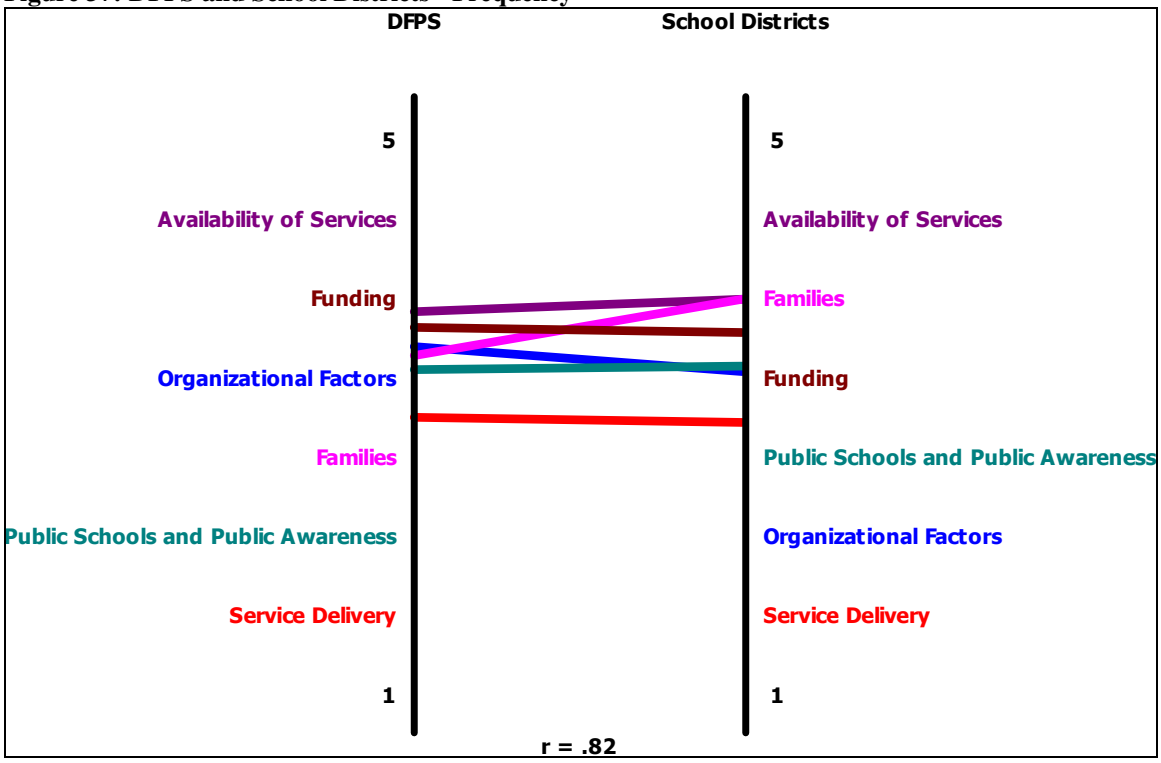
DFPS and School Districts

DFPS and school district employees disagreed on the second, third, fourth, and fifth cluster rankings (Figure 37). However, their average cluster ratings were similar as indicated by a maximum difference of .42 points (Table 65) and the pattern match suggests a very strong consistency (r = .82). The standard deviation scores for DFPS employees indicate consistency in responses within the group. As previously mentioned, the school district employees varied in their responses, which can be attributed to the small number of participants (n = 2).

Table 64: DFPS and School Districts- Frequency

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
DFPS (n = 12)	*x*	2.98	3.74	3.49	3.31	3.42	3.63
	sd	0.34	0.22	0.39	0.37	0.30	0.33
Schools (n = 2)	*x*	2.93	3.83	3.31	3.35	3.82	3.59
	sd	0.70	0.32	0.77	0.69	0.24	0.57

Figure 37: DFPS and School Districts - Frequency

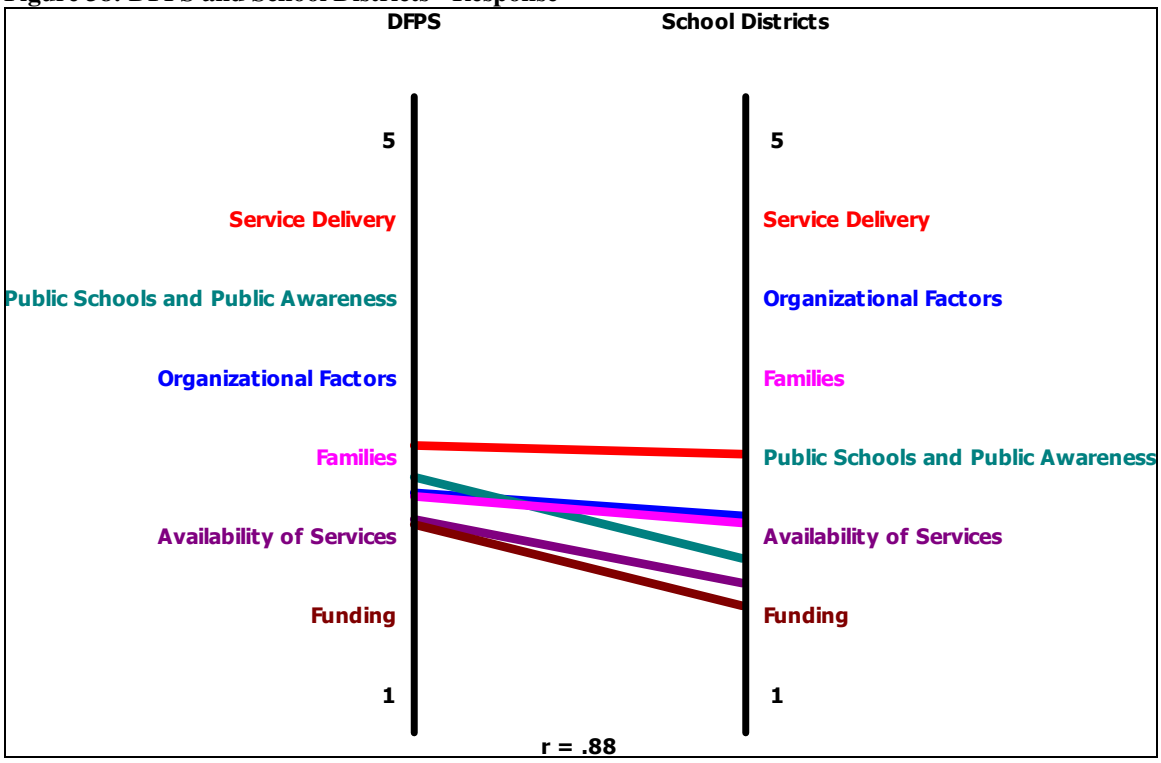


As for the response ratings, DFPS and school district employees disagreed on the second, third, and fourth cluster rankings (Figure 38), but their average cluster ratings were similar as indicated by a maximum difference of .58 points (Table 65). It is worth noting that overall school district employees tended to be more discouraged by the factors than DFPS employees. The pattern match indicates very strong consistency in responses between the groups (r = .88). The standard deviation scores for DFPS employees suggest consistency in their responses. Again, one should be cautious in interpreting these results due to the low number of school district employees (n = 2). The lack of school district employees also prevents the generalization of these results to the region.

Table 65: DFPS and School Districts - Response

		Service Delivery	Availability of Services	Organizational Factors	Public Schools and Public Awareness	Families	Funding
DFPS (n = 11)	*x*	2.78	2.24	2.44	2.54	2.40	2.20
	sd	0.42	0.24	0.31	0.24	0.28	0.26
Schools (n = 2)	*x*	2.71	1.78	2.27	1.96	2.21	1.62
	sd	1.12	0.44	0.75	0.50	0.56	0.36

Figure 38: DFPS and School Districts - Response



Go-Zones

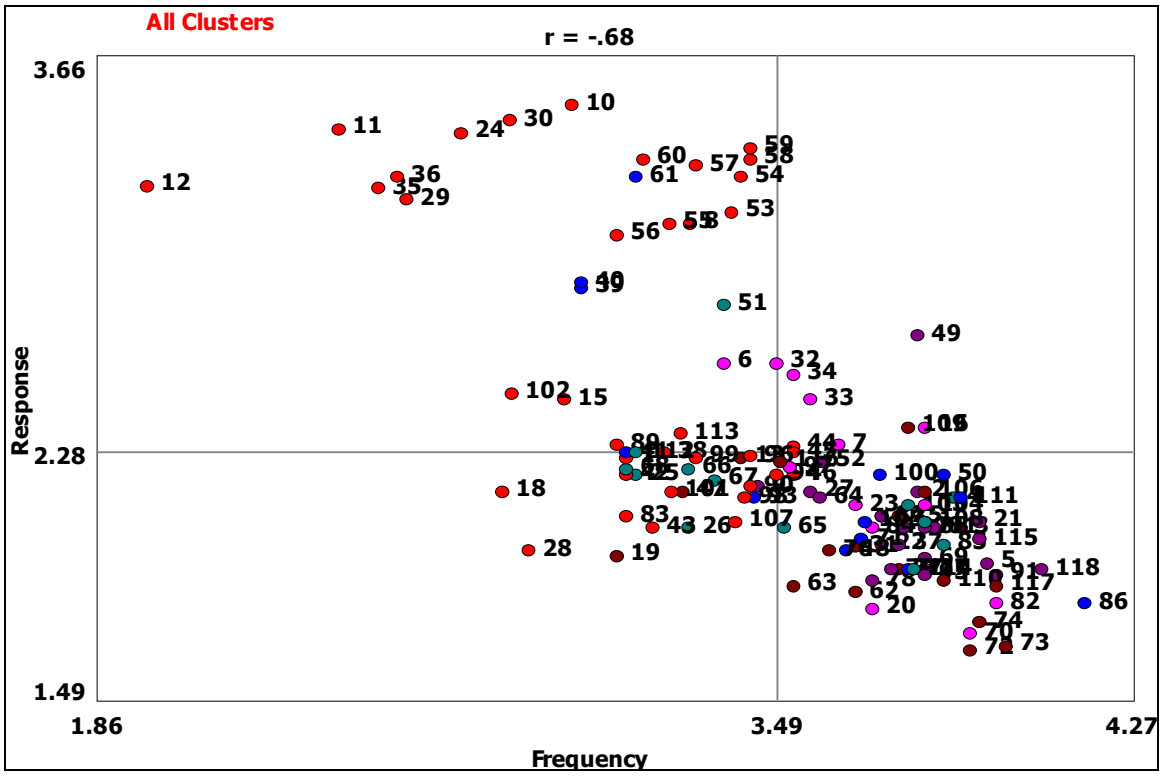
Go-zone maps are another helpful tool for examining the relationship between two rating scales, allowing for the identification of priority areas. The go-zone map is simply a graphical representation of a bivariate plot between two variables or rating scales (Trochim, Milstein, Wood, Jackson, & Pressler, 2004). For example, the go-zone map depicted below (Figure 39) represents a bivariate plot of the frequency and response ratings for all of the participants. Each point on the go-zone map represents a statement and the number next to each point corresponds with the statement numbers presented earlier in Tables 34 and 35. The points are also color coded, which correspond with the cluster colors used in the concept maps and pattern matches. The color codes for the clusters are as follows: Service Delivery (red), Availability of Services (purple), Organizational Factors (blue), Public Schools and Public Awareness (green), Families (pink), and Funding (brown). The numbers that fall along the right side and bottom of the map represent the response and frequency rating scales, respectively. The go-zone map also includes a vertical axis and a horizontal axis that divide the map into four quadrants. In terms of the maps generated for the current study, the quadrants provide the following information:

- Lower left quadrant- This quadrant represents statements that were rated low for both response (vertical axis) and frequency (horizontal axis).
- Upper left quadrant- This quadrant represents statements that were rated high for response and low for frequency.
- Upper right quadrant- This quadrant represents statements that were rated high for both frequency and response.
- Lower right quadrant- This quadrant represents statements that were rated low for response and high for frequency.

So, what can we learn from a bivariate plot of the rating data? In terms of the current study, the information provided could inform prioritization of items for an intervention or strategic plan. For instance, the items that fall in the lower right quadrant were rated high for frequency and low for response (participants tended to find these

statements/factors discouraging). In other words, these items occurred frequently (more than some of the time) and were perceived as discouraging, at best. Therefore, attempts to address factors that impact service delivery should include items from this quadrant. On the other hand, items in the upper left quadrant (rated high in response low in frequency) should also be considered when addressing this issue. Specifically, items in this quadrant represent factors that don't occur often, but are perceived as positive. Inclusion of these items could create opportunities for success, leading to an increase in trust, which is a key component of sustaining interventions. We may also want to focus enough resources to maintain factors that are viewed as encouraging and occurring frequently (upper right quadrant) and focus less resources on things that were viewed as being discouraging and occurring infrequently. Thus, the go-zones provide a visual representation of the rating data that is easy to interpret and apply to service planning.

Figure 39: Go-Zone for All Clusters



Since the heavy concentration of statements in the lower quadrants makes it difficult to identify all of the statements, a go-zone was generated for each cluster. Each cluster's go-zone map is followed by a table containing the statements and ratings for that particular cluster. Within each table, the statements that fall in the lower right quadrant (high frequency and low response) have been highlighted, making it easier to locate the related rating data. As demonstrated by the go-zone map for Service Delivery (Figure 40), there are seventeen statements that fall within the lower left quadrant (these statements are highlighted in Table 66). After reviewing these statements, the following common themes emerged: communication, knowledge, accountability, respect, service fragmentation, and working together. The go-zone map also notes an *r* of -.4, which is derived from a pattern match between response and frequency ratings for all participants. An *r* of -.4 suggests a moderate inverse relationship between response and frequency. In general, the more frequently a factor was encountered the less encouraging it was perceived as being.

Figure 40: Go-Zone for Service Delivery

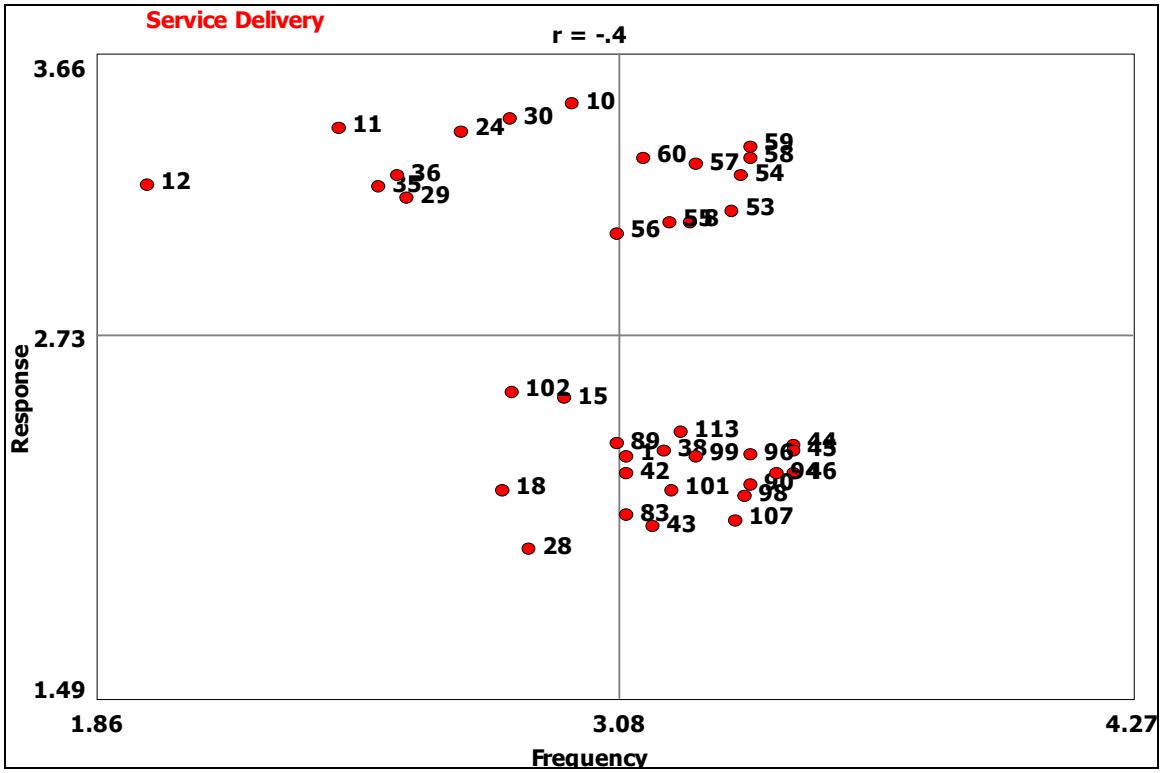


Table 66: Statements for Service Delivery Go-Zone

#	Statement	Freq	Resp
1.	the tendency of service providers to not look outside the box for possible answers or solutions to client issues	3.09	2.26
8.	the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions	3.26	3.19
10.	current collaborative efforts via Community Resource Coordination Group (CRCG)	2.95	3.66
11.	current collaborative efforts via CASA (Court Appointed Special Advocates)	2.35	3.56
12.	current collaborative efforts via Nacogdoches Safe and Drug Free	1.86	3.33
15.	service providers' limited familiarity with services	2.93	2.79
18.	the lack of follow through with services from professionals	2.77	2.12
24.	current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)	2.67	3.55
28.	the tendency of agencies to work against each other instead of together	2.84	1.88
29.	Memorandums of Understanding (MOUs)	2.52	3.29
30.	interagency staff meetings	2.79	3.60
35.	the use of mutual (interagency) training sessions to clarify agency policies	2.45	3.33
36.	the use of mutual (interagency) training sessions to clarify agency responsibilities	2.50	3.37
38.	the tendency to rush to judge clients and their problems because of the opinions of entities involved with the client	3.19	2.28
42.	reluctance of agencies to engage in staffings for common clients	3.09	2.19
43.	reluctance of agencies to communicate with one another	3.16	1.98
44.	the limited understanding of the policies of other agencies	3.52	2.30
45.	the limited understanding of the procedures of other agencies	3.52	2.28
46.	the limited understanding of the responsibilities of other agencies	3.52	2.19
53.	the ability of agencies to work together to serve the client and family	3.36	3.23
54.	the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)	3.39	3.37
55.	the degree to which agencies will allow for creativity in working with clients and their families	3.20	3.19
56.	familiarity with the processes of other agencies involved with the client	3.07	3.14
57.	mutual respect among agencies involved in delivering services to the client	3.27	3.42
58.	openness to the views of other agencies involved in delivering services to the client	3.41	3.44
59.	openness to the approaches of other agencies involved in delivering services to the client	3.41	3.49
60.	the ability of agencies to start where the client is	3.14	3.44
83.	service providers' limited understanding of mental health disorders	3.07	2.02
89.	limitations created by inconsistencies in agency confidentiality policies	3.07	2.31
90.	the lack of communication among agencies	3.41	2.14
94.	the lack of agencies' knowledge of services provided by other agencies	3.48	2.19
96.	a lack of interagency training	3.41	2.26
98.	the lack of a clear understanding of which agencies are responsible for what problems	3.40	2.10
99.	the inconsistencies between allocation of staff resources and client needs	3.27	2.26
101.	the unwillingness of providers to alter services to better meet the needs of clients	3.21	2.12
102.	service duplication	2.80	2.51
107.	the unwillingness of agencies to accept responsibility for the difficult cases	3.37	2.00
113.	the lack of communication among service providers	3.23	2.35

A total of nine statements fall in the lower right quadrant of the go-zone map for Availability of Services (Figure 41 & Table 67). The common themes appear to be transportation, geographic boundaries, service providers, out of home placements, and community-based services. The go-zone map notes an *r* of -.36, which suggests a low or weak inverse relationship between response and frequency. In general, the more frequently a factor was encountered the less encouraging it was perceived as being.

Figure 41: Go-Zone for Availability of Services

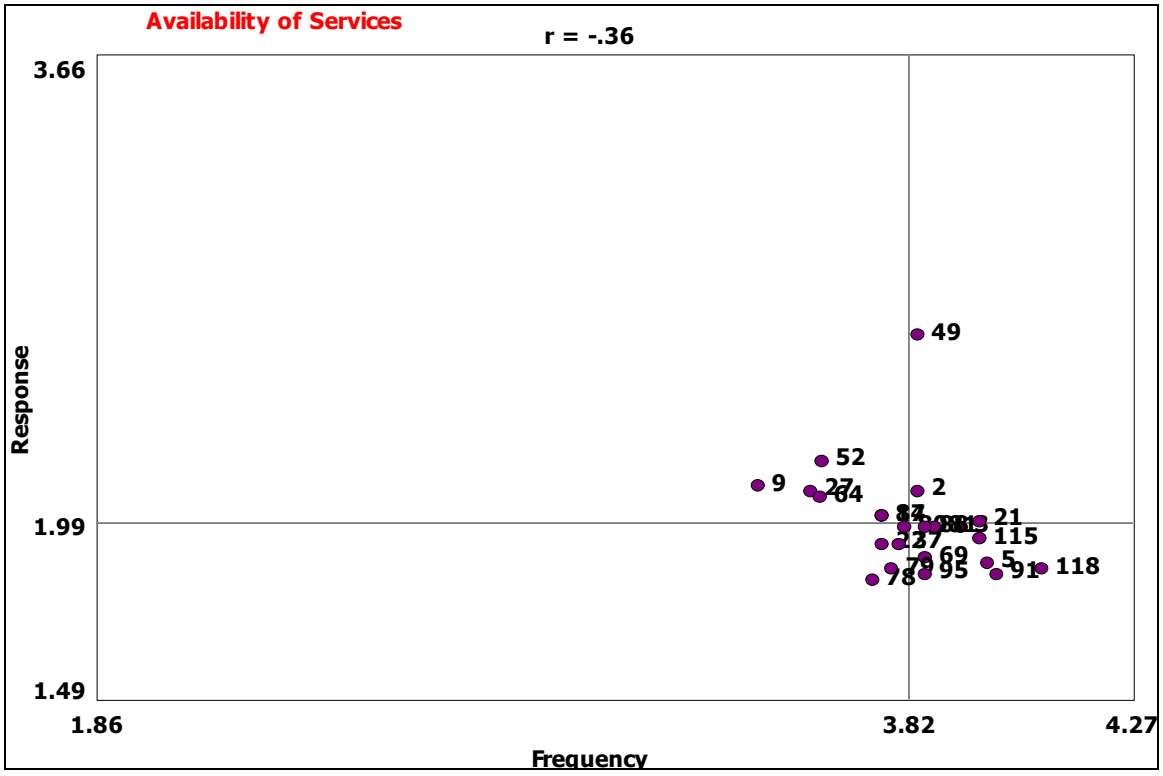


Table 67: Statements for Availability of Services Go-Zone

#	Statement	Freq	Resp
2.	The limited number of service providers for clients	3.84	2.12
3.	The limited number of local out-of-home placements for clients	3.95	1.98
5.	the high number of at-risk students compared to the limited resources available to serve them	4.02	1.83
9.	limited access to client transportation	3.43	2.14
14.	The lack of access to service providers within close proximity to rural areas	3.75	2.02
21.	the lack of support groups to help parents develop the skills they need to help their child	4.00	2.00
22.	The lack of community-based mentors to work with the child and service providers	3.75	1.91
27.	The distances families have to travel in order to receive services	3.57	2.12
37.	The limited availability of services in the local community	3.80	1.91
49.	The need for more home-based (in-home) services	3.84	2.74
52.	the lack of community based aftercare services to support clients once they are released from an out-of-home placement	3.60	2.24
64.	The distance clients must travel to access services	3.59	2.10
69.	The lack of family therapy services for mental health clients	3.86	1.86
78.	The lack of support services for clients	3.73	1.77
79.	The lack of support services for families	3.77	1.98
80.	The lack of summer support programs for clients	3.81	1.98
81.	The lack of summer support programs for families	3.88	1.98
87.	The lack of crisis services in locations that are easily accessible to clients	3.75	2.02
88.	The lack of inpatient crisis stabilization services	3.86	1.98
91.	The lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization	4.05	1.79
95.	limited availability of services in rural areas	3.86	1.79
115.	The lack of community-based parenting classes	4.00	1.93
118.	The lack of prevention services	4.16	1.81

A total of eight statements fall in the lower right quadrant of the go-zone map for Organizational Factors (Figure 42 & Table 68). The common themes are staffing issues and factors that interfere with service delivery. The go-zone map notes an *r* of -.81, which suggests a very strong inverse relationship between response and frequency. In general, the more frequently a factor was encountered the less encouraging it was perceived as being.

Figure 42: Go-Zone for Organizational Factors

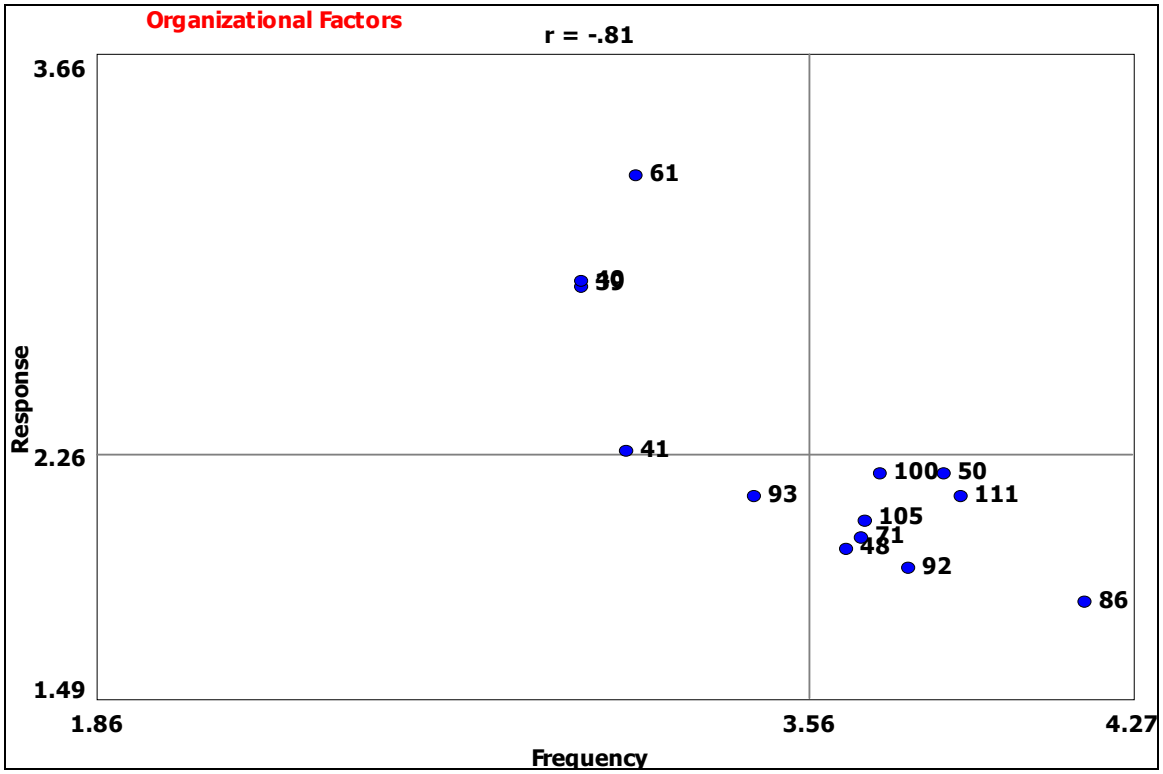


Table 68: Statements for Organizational Factors Go-Zone

#	Statement	Freq	Resp
39.	decentralized client services	2.98	2.93
40.	centralized client services	2.98	2.95
41.	The lack of familiarity among service providers with the nature of rural areas	3.09	2.28
48.	the high turnover rate of service providers	3.66	1.88
50.	too much emphasis on paperwork	3.91	2.19
61.	the ability of service providers to start where the client is	3.11	3.37
71.	the limited amount of time available per client due to service delivery expectations	3.70	1.93
86.	low wages for service providers	4.27	1.67
92.	Understaffing	3.82	1.81
93.	the lack of appropriately trained staff	3.42	2.09
100.	the limited amount of time available to provide for the needs of clients and their families	3.74	2.19
105.	the inability to spend the necessary amount of time with each individual case	3.70	2.00
111.	high caseloads	3.95	2.09

A total of six statements fall in the lower right quadrant of the go-zone map for Public Schools and Public Awareness (Figure 43 & Table 69). The only theme common to several statements is public awareness. Other themes include lack of services,

communication, funding, and advocacy. It is interesting that lack of services and communication were also common themes for Service Delivery and Availability of Services, respectively. The go-zone map notes an *r* of -.48, which suggests a moderate inverse relationship between response and frequency. In general, the more frequently a factor was encountered the less encouraging it was perceived as being.

Figure 43: Go-Zone for Public Schools and Public Awareness

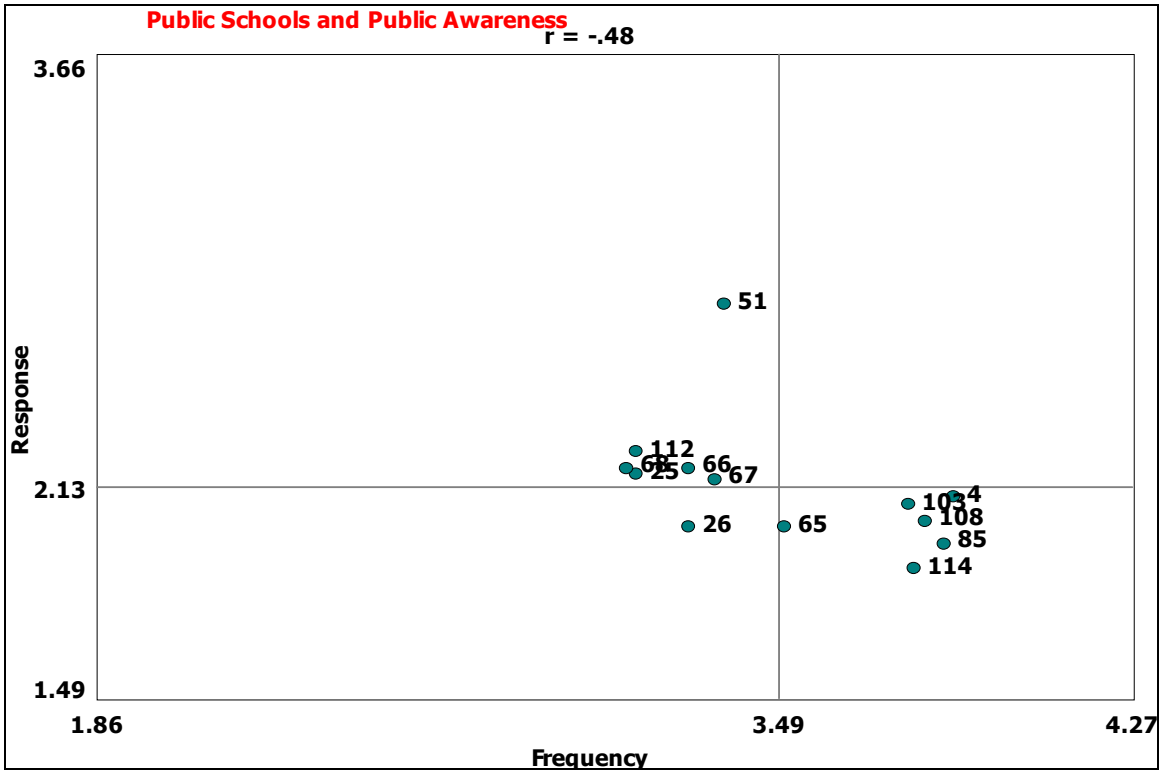


Table 69: Statements for Public Schools and Public Awareness Go-Zone

#	Statement	Freq	Resp
4.	the high number of at-risk students compared to the limited time available to serve them	3.93	2.10
25.	the lack of school-based resources to serve children identified as LD (learning disabled)	3.11	2.19
26.	the lack of school-based resources to serve children identified as ED (emotionally disturbed)	3.25	1.98
51.	the knowledge of available services	3.34	2.86
65.	the lack of communication between the school district and parents	3.50	1.98
66.	the lack of cooperation between the school district and mental health service providers	3.25	2.21

67.	the limited amount of time allowed by school districts for mental health service providers to meet with clients	3.32	2.16
68.	the unwillingness of school districts to allow mental health service providers to meet with clients at school	3.09	2.21
85.	the general public's limited understanding of mental health disorders	3.91	1.91
103.	the lack of local public awareness campaigns for children's mental health disorders	3.82	2.07
108.	the disconnect between current funding streams and client needs	3.86	2.00
112.	the unwillingness of schools to cooperate with social service providers	3.11	2.28
114.	the lack of advocates at the state level	3.83	1.81

A total of six statements fall in the lower right quadrant of the go-zone map for Families (Figure 44 & Table 70). The common themes were family involvement and understanding/awareness of mental health disorders. The go-zone map notes an *r* of -.80, which suggests a very strong inverse relationship between response and frequency. In general, the more frequently a factor was encountered the less encouraging it was perceived as being.

Figure 44: Go-Zone for Families

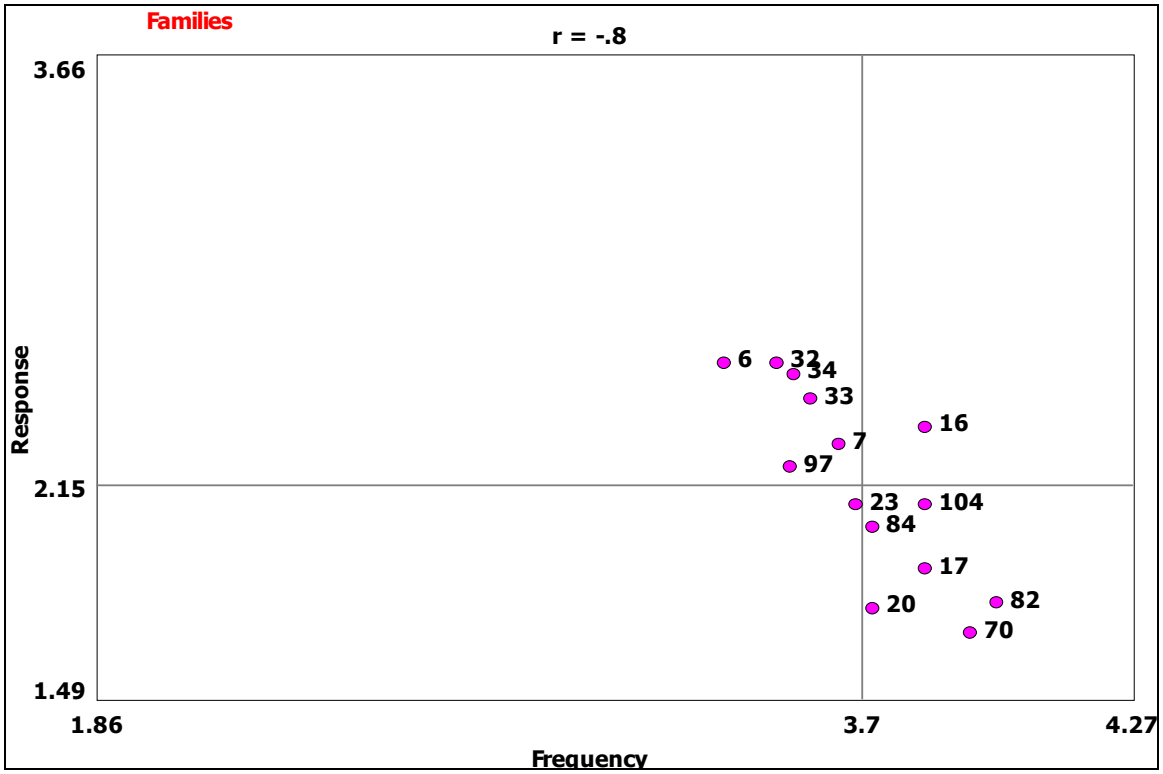


Table 70: Statements for Families Go-Zone

#	Statement	Freq	Resp
6.	the willingness of the client to participate with service providers	3.34	2.63
7.	the willingness of the client's parents to participate with service providers	3.64	2.31
16.	families' limited familiarity with services	3.86	2.37
17.	the lack of follow through with services from families	3.86	1.81
20.	the lack of consequences for parents who are not actively involved in services for their children	3.73	1.65
23.	the lack of school-based mentors to work with the child and service providers	3.68	2.07
32.	the willingness of clients to make substantive changes recommended by service providers	3.48	2.63
33.	the willingness of parents to make substantive changes recommended by service providers	3.57	2.49
34.	the willingness of families to make substantive changes recommended by service providers	3.52	2.58
70.	the lack of parent involvement with their children	3.98	1.56
82.	state legislators' limited understanding of mental health disorders	4.05	1.67
84.	families' limited understanding of mental health disorders	3.73	1.98
97.	an inability to educate the rural population of available resources	3.51	2.21
104.	the lack of local public awareness campaigns for children's mental health services	3.86	2.07

A total of six statements fall in the lower right quadrant of the go-zone map for Funding (Figure 45 & Table 71). The only theme common to several statements is government funding to support mental health services. Other themes include services for indigent clients and insurance coverage. The go-zone map notes an *r* of -.47, which suggests a moderate inverse relationship between response and frequency. In general, the more frequently a factor was encountered the less encouraging it was perceived as being.

Figure 45: Go-Zone for Funding

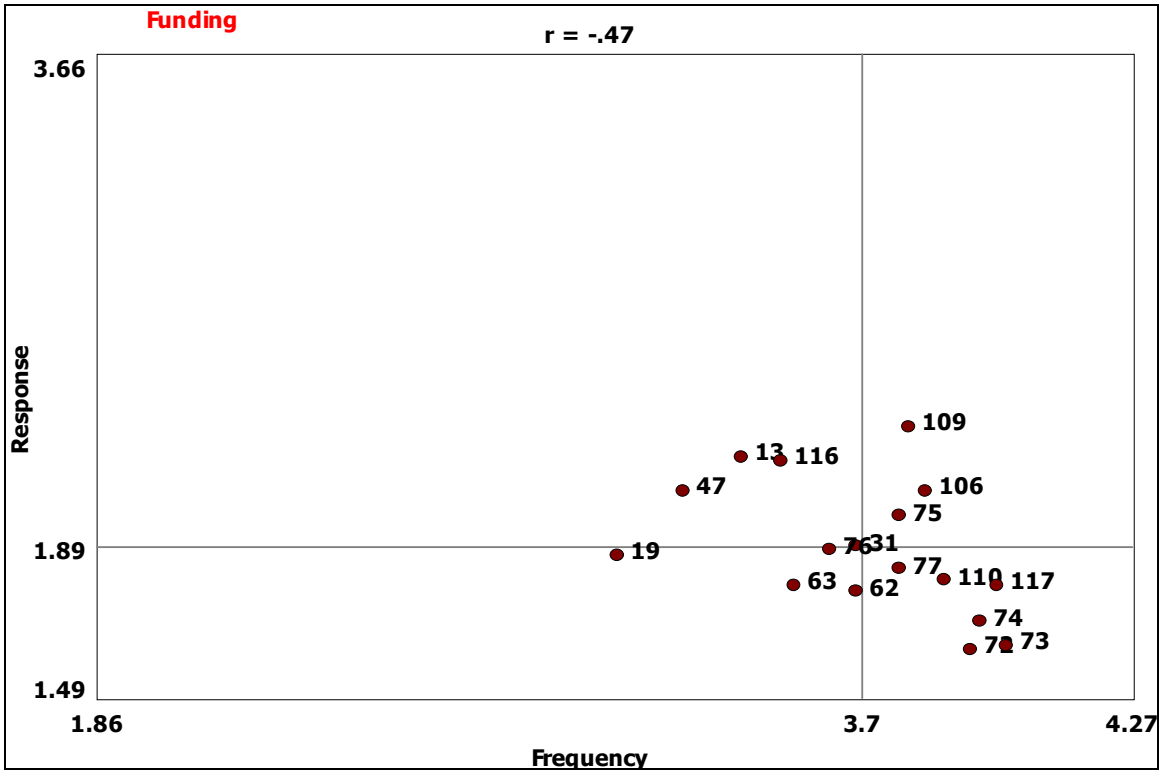


Table 71: Statements for Funding Go-Zone

#	Statement	Freq	Resp
13.	the client's ability to pay for services	3.39	2.26
19.	the unwillingness of Medicaid to provide comprehensive coverage to clients	3.07	1.86
31.	the lack of financial support available in the community to support service delivery	3.68	1.90
47.	the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)	3.24	2.12
62.	limited coverage of health insurance for mental health issues	3.68	1.72
63.	limited access to health insurance for clients	3.52	1.74
72.	the lack of local funding for mental health services	3.98	1.49
73.	the lack of state funding for mental health services	4.07	1.50
74.	the lack of federal funding for mental health services	4.00	1.60
75.	shorter stays for inpatient psychiatric services	3.80	2.02
76.	limited Medicaid coverage for inpatient psychiatric services	3.61	1.88
77.	limited insurance coverage for inpatient psychiatric services	3.80	1.81
106.	the lack of funding for collaborative projects	3.86	2.12
109.	the ability to find funding to meet the needs of individual counties	3.82	2.37
110.	the lack of funding to provide adequate services to clients	3.91	1.77
116.	inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services	3.49	2.24
117.	the lack of mental health services for clients who don't have a payer source	4.05	1.74

Social Services Questionnaire

Participants were asked to complete a questionnaire designed to gather information about their experiences with public social services for children who possess or are at-risk of emotional/behavioral issues (see Appendix D). Specifically, the questionnaire consisted of five open-ended items that asked participants to discuss positive and negative service delivery situations, things that they would change and keep the same, and perceptions of the difficulty associated with systematic change. The following subsections provide an overview of their responses.

Positive Situations

The first item on the questionnaire asked each participant to describe a positive situation in which he/she was directly involved during the course of delivering/receiving public social services for children who possess or are at-risk of emotional/behavioral issues. Forty-three of the 48 respondents chose to respond to this question. While the examples provided varied in terms of situations and participants, there were several common themes, including cooperation, joint planning, accessing appropriate services, client success, appropriate referrals, and parent involvement. Several participants described successes resulting from providers, parents and clients working together through the Special Needs Diversionary Program (SNDP), which was described in Chapter 1. A juvenile probation officer wrote that the SNDP program "seems to involve parents much more, and by being in the home seems to make difference." Additional comments regarding the SNDP program include:

> Having both a juvenile probation officer and a counselor assigned to our son's case gave added support for us and him. They met at our home on a regular basis over a course of several months. It gave John* someone else to be accountable to for his actions as well as ourselves as parents. It helped keep everything going in a forward direction. Our son and ourselves could see ongoing progress being

* Pseudonym was used to ensure confidentiality.

made. When a set back did occur there was immediate help to get everyone back on track. *Parent.*

A youth involved in the special needs diversionary program was able to be linked up with the mental health authority (Burke Center). The youth received medication for bipolar disorder, and the following results happened- youth obtained GED, reduction in impulsive relationship with grandparents who were taking care of him, employment in community, successful completion of probation. *Juvenile Probation Officer.*

At one time our department (juvenile probation) had the TCOMI [SNDP] program. This cooperative program with Burke Center was effective in delivering the services of both agencies to children with both delinquent and emotional problems. This type of approach shows that multiple agencies can work together. *Administrator, Juvenile Probation.*

Another common situation was cooperation among mental health providers and school district employees. The following response exemplifies such situations:

I was able to provide counseling to family as well as work with them in the school. School staff worked with me to develop a plan to help the child do better. I was able to go into the school system and work with the child there as well. *Direct service provider, Local Mental Health Authority.*

Finally, respondents also frequently mentioned collaboration among providers through local meetings, such as interagency councils and CRCG (Community Resource Coordination Group). For example, a supervisor for the Local Mental Health Authority noted that "CRCG meetings are [an] excellent resource for helping identify and providing a number of resources for children. I have dealt with several situations dealing with families who have benefited from their services." Sadly, several respondents stated that they had not experienced a positive situation in the course of delivering services.

Negative Situations

The second item on the questionnaire asked each participant to describe a negative situation in which he/she was directly involved during the course of delivering/receiving public social services for children who possess or are at-risk of emotional/behavioral issues. Forty-six of the 48 respondents chose to respond to this question. In reviewing the responses to this question, an overarching theme was evident around difficulty with accessing appropriate services for clients. A variety of situations were described, with the most common being those related to school-based services, child protective services, residential treatment and mental health services. In terms of schools, the following situations are representative of the difficulties schools, providers, parents and clients face when attempting to deliver appropriate educational services:

> A 13 year old male was placed in John Doe ISD[*] and was mainstreamed. Which was something he was not used to. This child[‘s] IQ is in the lower 60 and he has a lot of anger issues and behavioral issues. His behaviors at the school became so bad that they were going to kick him out, there [*sic*] excuse for not placing in AB [adaptive behavior] classes was they did not have one at that campus. After an ARD [Admission, Review, Dismissal] meeting they chose not to kick him out but to send him to another campus w/an AB unit. He lasted about 1 month and during this month the school called on 3 different occasions to come get him. He was moved to the Dallas area, and then back to Tyler. Once in Tyler, he last for about a month and they informed the dept that their program was not in his best interest due to his IQ. This child is currently in Houston, Texas. *Direct service provider, Texas Department of Family and Protective Services.*

> Attempting to work with parent and child to access special education services for child. School [was] very apprehensive and often difficult to work with and often refused to help in testing and developing alternative interventions beside suspension. Parent had to pay for psychological to prove to school that child had

[*] Pseudonym was used to ensure confidentiality.

> emotional issues. School often made parent go through unnecessary steps and referrals. Failed 3x without school attempting to assess problems or issues. *Juvenile Probation Officer.*

Several respondents reported difficulty in accessing child protective services for clients older than 10 years of age, especially teenagers. For example:

> Referring child that is 15 and nothing will be done because of his age. He is [*sic*] not been provided food and lights in his room. When CPS was called said that they would take the referral but nothing was going to be done because of his age. *Juvenile Probation Officer.*

Respondents also discussed the barriers parents and providers face when attempting to access residential treatment, especially for children who present serious behavior problems and/or are not in the care of DFPS.

> Several situations involve parents calling looking for residential services for their children as a result of child exhibiting extreme behavioral problems including stealing, aggression, etc. Often these parents find that there are little to no resources (particularly for residential care) for children unless they are in CPS care. *Supervisor, Residential Treatment Facility.*

Finally, a large number of participants discussed challenges to accessing community based mental health services and inpatient psychiatric services. A parent reported that "limited resources prohibited John* from getting his needs [met] for several weeks as we had to wait for the appointment with the doctor- If the doctor was on staff more often, this would not have been an issue." Other examples of difficulties in accessing mental health services include the following:

> Have been unable to get children in to see a psychiatrist for several weeks due to lack of open times. Have had agencies say a child it [*sic*] not eligible for services, but give no other alternative suggestions as option. Have been told that because a child has an assaultive offense alleged that they are ineligible for hospitalization, even though they are suicidal. *Juvenile Probation Officer.*

* Pseudonym was used to ensure confidentiality.

> Treatment related issue. Adolescent male threatening suicide. It took myself and FCA [Local Mental Health Authority] hours to find help for him. He was transported to Vernon State Hospital and released in 3 days. He returned to treatment still threatening and the ordeal began again! *Direct service provider, Local Mental Health Authority.*

In addition to difficulties related to accessing services, several other common themes were present in the responses. As highlighted by the following examples, one such theme was the overuse or inappropriate use of the juvenile justice system to access services.

> The negative that I see repeatedly is that the juvenile justice department is often a youths [*sic*] last chance to get the help they need after being denied services from other agencies. It often takes making a youth a "criminal" before services are available to them and their families. *Juvenile Probation Officer.*

> Most negative situations that I have been involved with over the past eight years deals primarily with the exhaustion of services. Residents come into the detention center that have been treated over the past years and not [*sic*] one is willing to work with these children any longer. Therefore, we are often the dumping ground for children suffering from MR, MH, emotional and behavioral problems. *Administrator, Juvenile Probation.*

Not surprisingly, a lack of cooperation among service providers and agencies was commonly noted. One comment was especially interesting in that it demonstrated the importance of state level cooperation to local level initiatives.

> Our department got out of the TCOMI [SNDP] program for several reasons. One was the lack of cooperation from our respective state agencies. Both Texas Juvenile Probation Commission and the [Texas] Council on Offenders with Mental Impairment failed to resolve common issues and concerns. This taught

> me that for a cooperative program to be effective it must have the full support of the state level as well as the local level. *Administrator, Juvenile Probation.*

Other common themes included issues with eligibility criteria, uninvolved parents, and transportation. Several respondents noted that current eligibility criteria create service gaps and often times exclude clients who truly need assistance. The following example discusses the premature discharge of a child from residential treatment.

> A client's level of care was decreased to moderate- making her ineligible to continue in her psychiatric RTC placement- It was my opinion that she would not be able to handle the less restrictive environment. The facility disagreed with me. The young lady was moved 9 times including 3 hospitalizations and one placement in Juv. Detention after she was arrested. Finally I was able to get her level of care raised back up and she was returned to the original placement. *Direct service provider, Texas Department of Family and Protective Services.*

In terms of parent involvement, several respondents spoke about the negative impact of uninvolved or uncooperative parents. For instance, an administrator for a juvenile probation department reported that a

> 16 year old boy [was] referred for assault on family member. He has obvious mental health issues but his parent refuses to follow through with any resource referrals. Family moves frequently, very unstable conditions. Father will not apply for CHIPS or Medicaid, child is not on probation, case still pending. Child was recently hospitalized for mental health issues. Father picked him up and dropped him off with someone he had just met. Could not give us person's last name. Did not follow through w/ referral for aftercare or have child's prescriptions filled. When father appears in court he always tells judge he just wants help for his child, but not one will help him.

While most respondents did not directly mention transportation, as noted earlier in the dissertation, it significantly impacts the ability of clients to access services. As demonstrated by a juvenile probation officer's response, transporting clients often falls on the service provider: "Transportation issues surrounding getting people to and from the

multiple appointments that many people must make with these issues. I have personally taken youth/parents to appointments due to the poor public transportation system in Lufkin, Nacogdoches."

Things to Change

The third item on the questionnaire was as follows: "If you were involved in changing public social services for children who possess or are at-risk of emotional/behavioral issues, what is one thing that you would change? Please explain your answer." Forty-five of the 48 respondents chose to respond to this question. The most common themes involved increasing services, providers, programs and funding for social services. There were many insightful responses regarding changing the current system, including the following statements offered by juvenile probation officers:

- "I would make more preventative type services available, or early-intervention services so that youth are getting the help they need sooner. Services today are only available to the sickest of the sick, I would change that."
- "…the amount of visits should be increased. I would rather pay tax $ trying to help keep kids out of the system by being able to provide more services, rather than pay the expense to how [*sic*] them."
- "There needs to be more beds available for our crisis situations, such as suicidal children, even if they have charges pending. The idea that a child is too dangerous to hospitalize, but too unstable to detain makes little sense."

A direct service provider for the Local Mental Health Authority noted the difficulties created by the State of Texas' Resiliency and Disease Management Model (previously discussed in the literature review). Specifically, the provider said that "sometimes we are very limited in what we can do to help [a] family because of the state requirements. Some couples need couples therapy to help their children and we have to refer [them] out due to state requirements." As for mental health funding, a direct service provider for the Local Mental Health Authority stated that she would change "funding and getting children an appointment quickly with affordable fees. To [*sic*] many limits on

requirements, financial requirements. Leaves a lot of loop holes. Children then fall between the cracks and do not get help!" Finally, a juvenile probation officer offered the following comment regarding funding:

> I would definitely change the amount of funding that is allotted for public social services. An increase in local, state, and federal funding for public social services would allow funds for those families without insurance who don't qualify for Medicaid. An increase in funding would prevent understaffing. Additionally, an increase in funding would allow funds for prevention services, public awareness, additional service providers, and an increase in wages for service providers.

Several respondents provided additional details in their responses, including changes that they would make to specific agencies, including Burke Center (LMHA), TDFPS, and schools. For instance, a direct service provider for TDFPS suggested slowing down the investigation process to prevent premature and/or unnecessary out of home placements. The same individual recommended combining investigations and conservatorship positions to ensure continuity of care. A juvenile probation officer suggested the following changes for TDFPS:

> I would like to change the way Child Protective Services work with other agencies. I believe that CPS should be available to help all children and sometime[s] when we really need the agency to step in and do their job they do not cooperate. So I would like to see some changes in the way CPS works with other agencies.

Other respondents noted the importance of enhancing the ability of schools to identify and meet the needs of children with emotional and/or behavioral issues. A parent wrote that "I do see tremendous changes needed in the public school system for at-risk children—many who have learning and/or emotional disabilities." A juvenile probation officer suggested placing more services in the schools, noting that:

> Children spend as much time at school as they do anywhere else. Schools are not equipped to deal with these types of students the way juvenile officers and others are. We are able to recognize signs that others may not.

Although it was not a common theme, an Administrator of a juvenile probation department noted all service providers need to be held accountable at the local level. The administrator said that "when agencies have to be accountable on a local level, things get done. When there is just a distant voice in Austin deciding whether or not a child receives services, it often does not happen."

Whereas many of the comments focused on increasing services, providers, and funding, several other prominent themes were present, including the need for cooperation, collaboration, and communication among providers. For example, one respondent noted that a holistic approach to clients requires agencies to work together.

> I would like to see a universal approach to service delivery. Each individual is served by many different agencies but everyone uses the same plan. Every agency had a part and the whole person is served. Today services seem fractured with agencies only concerned with their individual agency's responsibility. The school system is concerned about education matters but if there is a universal plan, every agency does more by the extent of the plan. *Direct service provider, Independent School District.*

Another suggestion was that agencies work together to develop centralized access points, as well as common assessment tools and diagnostic criteria. Several respondents identified the impact of lack of communication on service delivery. For instance, a direct service provider for the Local Mental Health Authority stated that "their [*sic*] seems to be lack of communication between service providers. Sometimes services are overlapped, missed or ineffective." Additional themes included the need for public education/awareness campaigns about mental illness, efforts to educate parents about available resources, and more qualified social service professionals in rural areas. A direct service provider for the Local Mental Health Authority offered the following comment regarding the need for more professionals: "… many people in the field have a bachelor's degree or less and their training is very limited. I believe staff working with children need at least a master's degree."

A general summary of the suggestions for changes in social services for children who possess or are at-risk of emotional/behavioral issues is provided below.

- Offering more services for families, such as parenting classes, respite care, in-home family services, and parent support groups
- Mentoring programs for children, especially girls
- Increasing the availability of services for those who are indigent and/or without adequate insurance coverage
- Focusing on prevention and early intervention programs, especially through the schools
- More funding for long term treatment services, such as residential treatment
- A comprehensive caseworker system to support children returning to the community from out of home placements
- Runaway shelters
- Additional professionals, especially psychiatrists and psychologists who are trained to work with children
- Short-term and crisis intervention services, such as an inpatient psychiatric stabilization unit
- Comprehensive support services for children who "age out" of the foster care system
- Reduce the time clients have to wait for services, especially services provided by the Local Mental Health Authority.

Things to Keep the Same

The fourth item on the questionnaire was as follows: "If you were involved in changing public social services for children who possess or are at-risk of emotional/behavioral issues, what is one thing that you would keep the same? Please explain your answer." Forty-one of the 48 respondents chose to respond to this question. However, four of the forty-one stated in various terms that they did not know what they would leave unchanged. One of the most common things noted as needing to be kept the

same were CRCGs (Community Resource Coordination Groups). A local school district administrator noted the importance of the CRCG to collaboration, "We do have a large number of service providers who care and are committed to students at-risk. The CRCG group has been one effective intervention for some cases. This is a great place to begin improving collaboration." An administrator for a juvenile probation department highlighted the importance of CRCG to accountability, "CRCG, when everyone attends, is a good way to stay current with what resources are available. Most importantly, it also holds members accountable for delivering services and following through." Another juvenile probation administrator pointed out the need to provide CRCGs with funds to carry out their mandates, "I would keep the CRCG in operation but make available funds so it can implement services for children who are presented to them."

In addition to CRCGs, many respondents mentioned the SNDP and services to those with limited financial resources. For instance, a juvenile probation officer stated "I would also keep the SNDP program. I feel that home intervention truly works with these types of children. I do think that the program needs to be longer." These sentiments were supported by a parent who spoke of the importance of SNDP services to families,

> Programs like TACOMI [TCOMI, SNDP]. Not only the great support it gives the family, the coping skills the counselor tried to help give the client and family. Also, I could see how much more it would be of help to families lacking resources to afford help. The fact that it is in home eliminates pressure of parents who maybe don't have transportation to otherwise take their child to his/her appointments.

As for services to those with limited financial resources, a direct service provider for the Local Mental Health Authority offered the following insight,

> Keeping local MHMRAs in place as catchment areas for at risk youth whose services can be provided at a sliding fee scale to have access to doctor services, counseling, service coordination to prevent mental health crisis that would fall to local ERs [emergency rooms] to manage.

A comment from another direct service provider for the Local Mental Health Authority echoed these concerns, "Medicaid/Burke Center/STAR provide free services. To keep these but expand them and fund them better."

Additional comments focused on collaboration and agency characteristics. Specifically, many respondents noted that they could see evidence of collaboration, cooperation, and networking. A direct service provider for the Local Mental Health Authority gave the following response, "coordination with other public and private agencies for treatment and/or schooling." A direct service provider for a local independent school district provided more detail in the following statement,

> The collaboration effort made by the many agencies that provide services for children. In John Doe and Jane Doe Counties[*], all of the probation personnel are accessible and work together with schools to provide services. The local mental health authority (Burke Center) also can be contacted when referrals are needed most of the agencies that provide services are open and accessible to helping provide services.

It is also important to note that several respondents mentioned that although there was evidence of collaboration among providers, there was definitely room for improvement. Overall, the following sentiments offered by a juvenile probation officer seemed to resonate through the responses, "I would definitely want to maintain the dedication and determination that the majority of service providers possess."

Level of Difficulty Associated with Systemic Change

The final item on the questionnaire asked respondents their opinion regarding the degree of ease or difficulty involved in changing the current public social services system for children who possess or are at-risk of emotional/behavioral issues. Forty-six of the 48 respondents chose to respond to this question. Not surprisingly, most of the respondents believed that it would be difficult, if not impossible, to change the current public social services systems. Of those who elaborated on their response, the majority cited money,

[*] Pseudonym was used to ensure confidentiality.

bureaucracy, government, and/or resistance to change as the key barriers to change. In terms of funding, a Juvenile Probation Officer offered the following opinion,

> I believe if money (funding) would not be a factor, it would be easy to change the current public social service system. In other words, it could be possible. In reality the likelihood that the social service system receives all the funding necessary is not practical.

The above sentiments were present in many of the responses, including:

- "I believe it will be difficult to change the current system without additional funds. The agencies involved are doing all they can with the limited resources available." *Administrator, Juvenile Probation Department*
- "The two biggest issues I see are money and time. All those who served this group are short handed and not well funded. I feel that most of us are doing all we can with our current resources." *Administrator, ISD*
- "It would be very difficult. Because there is [*sic*] no funds threw [*sic*] government assistance for children with mental illness everything is being cut." *Parent*
- "I think it will be difficult because it will take a lot more funding! Whenever money is an issue it makes the changes more difficult." *Juvenile Probation Officer*
- "Almost impossible because of government funding for service and/or services in a timely manner. Waiting periods to get children appointments for services." *Direct Service Provider, Local Mental Health Authority*
- "Difficult due to the amount of money that is needed to fund programs." *Direct Service Provider, Local Mental Health Authority*
- "It would be very difficult due to financial constraints." *Parent*

As demonstrated by the preceding comments, the concerns regarding funding were seen across respondent categories, i.e., parents, direct service providers, administrators, juvenile probation and mental health.

Although funding was the most commonly noted challenge to change, the nature of bureaucracies as a barrier to organizational change and collaboration with other entities was a common theme. In fact, a juvenile probation administrator suggested that funding was not the answer if agencies were to continue operating under their current structure. Specifically, the administrator's comment was "Difficult- more funding needed but not to sustain or add to administrative quagmire. The more agencies continue to duplicate the current structures of TDCJ and HHSC- there will not be significant improvement." Other respondents noted that size alone presented a barrier to change. For example, a direct service provider for the Local Mental Health Authority said, "Difficult, anytime you change something that is so large it take[s] a lot of time and effort." A supervisor for a residential treatment facility spoke to the issues of agency size in the context of TDFPS,

> As I am more familiar with CPS, it seems as if it is very difficult to make changes in policy. Unfortunately, the policy changes made do not seem to make much difference in the services offered. It also seems very difficult for TDFPS to offer a continuity in care as they do not always seem to communicate well with employees. It seems more difficult to alter larger social service bureaucracies.

The final common theme within the context of bureaucracy addressed the impact of bureaucratic structure upon service delivery and collaboration. A direct service provider for the Local Mental Health Authority summarized this issue with the following comment,

> most likely difficult due to levels of bureaucratic tape that interfere with delivering services from school, MHMRAs, private providers, etc. Probation confidentiality, access to records, collaboration, between different entities- differing assessment techniques, differing interpretation of assessments- public awareness of it even being a problem between mental health and deviant behavior.

Concerns related to the legislature were as common as those regarding bureaucracies. Within the category of legislative concerns, respondents noted the lack of

connectivity between consumers and legislators. For example, a supervisor for TDFPS felt that change would be "Difficult due to legislature- they are so far removed from problems that they don't understand the needs of our families." A juvenile probation officer expanded on this viewpoint, noting that not only would the legislature have to understand the issues faced by clients, but it would also have to be willing to commit adequate funding. Specifically, the officer said,

> Tremendous as it would take so much money and understanding from law makers who seem to be so far out of touch from these kids reality to see the benefits at dumping more $ to CPS schools, DHS, juv probation etc.

In addition to a lack of understanding among legislators, respondents identified the priorities or concerns of legislators as an issue. Respondents' concerns are exemplified by the following viewpoint offered by a parent,

> I believe bringing about change to current public social services for children who possess or are at-risk of emotional/behavioral issues seems impossible because it isn't a priority item for the state or federal government. Also as lack of knowledge and understanding of mental health issues exists within the local community.

The following viewpoint offered by a juvenile probation officer is also representative of sentiments regarding legislative concerns, "Very difficult. The state appears to be more concerned with cutting social service funds and reducing law suits then the long term consequences to society and community."

Although they were not as common as the previously mentioned themes, there are several themes that are important to mention, including resistance to change, challenges specific to rural areas, and service cuts. Several respondents identified resistance to change as a barrier to changing the current system. In general, the following response offered by a juvenile probation officer is representative of these responses, "I think that changing the current public social services system would be very difficult. Due to the fact that most people do not like change and they are not receptive to doing things differently." Interestingly, a juvenile probation officer discussed reluctance to change in

the context of bureaucracies, "I believe it would be fairly difficult due to the current heavily bureaucratic system that exists and because of the lack of resources and the unwillingness for entrenched people to change." A couple of respondents shared the perception that change is unlikely unless there is a significant precipitating event, which is exemplified by the following comment made by a TDFPS supervisor, "In my opinion it will remain difficult because of the political atmosphere. During an election year combined with a couple of high profile cases involving juveniles with mental health needs would be when the ball would start rolling." As for comments regarding rural areas, respondents noted the difficulty rural areas face in attracting/retaining qualified professionals and their inability to compete with urban areas for resources. In fact, a juvenile probation officer suggested that, "the current system is heavily slanted towards helping more urban areas and vastly underserves rural areas." Comments regarding service cuts are consistent with the following response from a juvenile probation officer

> Sometimes I think it would be easy, but yet I know that it is a constant battle to deal with. Laws change on a regular basis and it just seems like they keep cutting services, so I am sure it would be hard.

For the sake of fairness and ending on a positive note, three respondents were more positive in their assessment of change potential. A supervisor for TDFPS felt that change was "not hard if all agencies would pull together and push for these services." A juvenile probation officer was even more positive, stating that "It is not that hard. If you have an idea, go with it. If it works, other people will take notice." The most optimistic response was offered by a juvenile probation administrator, who said, "I believe we are close to a change. It appears we have legislators backing the system." While the perceptions of these individuals weren't necessarily consistent with the other respondents, their optimism is a refreshing and necessary component of change. Interestingly, the two juvenile probation employees work for a department that has a reputation for taking a progressive approach to working with clients.

CHAPTER 5- DISCUSSION AND IMPLICATIONS

As discussed in previous chapters, there are a number of factors that impact the delivery of social services to Texas children who possess or are at-risk of emotional/behavioral issues. While there many sources that attend to such factors, most examine them from an urban perspective, with little or no attention given to rural areas. Given that rural areas possess unique strengths and issues related to the delivery of social services, it is important to examine service delivery in a rural context. However, one must be mindful that rurality is not monolithic. There is a significant amount of variance among rural communities. Therefore, addressing rural service delivery issues requires an in depth understanding of the particular community or region. The current study was designed to examine the delivery of social services to rural East Texas children who are either at-risk of or possess emotional/behavioral issues. The specific aim of the study was to answer the following two research questions:

1. *How does the current structure of public social services for children who are at risk of or possess emotional/behavioral issues affect the ability of service providers to develop and maintain interorganizational relationships?*
2. *How does the current structure of public social services for children who are at risk of or possess emotional/behavioral issues affect service delivery to rural East Texas clients and their families?*

Concept mapping was employed to gather input from service providers, administrators, and parents of children involved with social services for children who are at-risk of or possess emotional/behavioral issues. Specifically, participants generated action statements, which they then sorted into groups based on conceptual similarity and rated in terms of frequency and response. This information was then processed using the Concept System® software (© 1989-2007 Concept Systems Inc., All Rights Reserved), which assists in the creation of a concept map, as well as statement ratings, cluster ratings, and pattern matches (see Chapter 3 for a detailed description of the process). The process resulted in the identification of 118 factors that impact the delivery of social services. Participants then sorted the factors into one of the following conceptual

domains: Service Delivery; Availability of Services; Organizational Factors; Public Schools and Public Awareness; Families; and Funding.

The final activity of the Concept Mapping process required participants to rate each of the factors or statements in terms of frequency and response. Although the results of this process were discussed in Chapter 4, several points are worth revisiting. For all participants, the average cluster ratings for frequency ranged from 3.08 to 3.82 and the average cluster ratings for response ranged from 1.89 to 2.73. The range of less than 1 point suggests that in general participants perceived the clusters as occurring with the same amount of frequency (some of the time to most of the time) and had a similar response (very discouraging to neither discouraging, nor encouraging) to the cluster items. These results suggest that each cluster should be given equal consideration in decision-making. Furthermore, specific decisions should be based upon ratings for individual statements (see Tables 38 and 39) and the go-zones (see Figures 39-45 and Tables 66-71).

The rating data was also used to compare the perceptions of various stakeholder groups who participated in the study. The purpose of these comparisons was to identify potential points of consensus and disagreement. Such knowledge can prove extremely useful to consensus building and the decision-making process. Interestingly, the results of the pattern matches suggest that the stakeholder groups are in agreement regarding the frequency and response ratings. Specifically, the difference in average cluster ratings for frequency ranged from 0.12 to 0.64 and the difference in average cluster ratings for response ranged from 0.12 to 0.60. Furthermore, the correlation coefficients for the pattern matches ranged from 0.72 to 0.99, meaning that all of the correlations were direct and ranged from strong to very strong. Given the history of difficulties and animosity among various stakeholder groups, the results are surprisingly positive. The within group standard deviation scores ranged from 0.15 to 0.77, indicating a fair amount of agreement among group members. The only exception being the maximum standard deviation score for school district employees, which is understandable given that only two completed the rating instruments. Other interesting results from the pattern matches included:

- When comparing parents and service providers for the response rating scale, overall parents were more positive in their responses. However, due to the low number of parents (n= 3), one must be cautious when interpreting the results.
- When comparing LMHA employees and DFPS employees for the response rating scale, DFPS employees were more positive in their responses, but still discouraged.
- When comparing juvenile probation employees and DFPS employees for the frequency rating scale, the overall cluster ratings for DFPS employees were lower than those for juvenile probation employees, suggesting that DFPS employees experienced the factors less frequently.
- When comparing juvenile probation employees and DFPS employees for the response rating scale, juvenile probation employees were more discouraged by the factors than DFPS employees. This seems reasonable given that juvenile probation employees reported experiencing the factors more often than DFPS employees.

In addition to the Concept Mapping process, participants were asked to complete a questionnaire consisting of open-ended items that asked participants to discuss positive and negative service delivery situations, things that they would change and keep the same, and perceptions of the difficulty associated with systematic change. Participant responses to these questions were helpful in understanding the results of the Concept Mapping process. These results, as well as those from the Concept Mapping process, are discussed in the following sections. Specifically, a section has been dedicated to discussing each conceptual domain and its relevance to the literature review and responses from the social services questionnaire. The later part of this chapter will address the limitations of the study and the implications for interorganizational relationships and service delivery.

Service Delivery

The first cluster in the concept map is Service Delivery, which consists of 38 factors that impact service delivery. It is important to note that Service Delivery was ranked the lowest in every group comparison for the frequency rating scale and ranked the highest in every group comparison for the response scale. A thematic analysis of the factors yielded the following themes: communication, knowledge, accountability, respect, service availability, and working together. The majority of the factors were viewed as being discouraging to very discouraging, with the exception of those related to current cooperative efforts (CRCG, CASA, and SNDP), MOUs, interagency trainings, capacity to work together, mutual respect, and openness to other approaches to service delivery. Despite the overall negative perception of the factors, the results are important to understanding the current social services system.

Communication among service providers and organizations was a commonly identified factor and was mentioned numerous times in the social services questionnaire responses. Respondents tended to agree that organizations and staff do not always communicate with one another. In fact, they reported a reluctance to do so. Reportedly, this even occurred when there were common clients involved. A potential source of miscommunication could be the lack of understanding of other agencies, which occurred more than sometimes and was perceived as being discouraging. It is also possible that miscommunications are related to a lack of knowledge and understanding regarding clients and services.

In terms of knowledge, respondents reported that issues related to the lack of knowledge were common and discouraging. Specific areas of knowledge and understanding included: available services; policies, procedures, responsibilities and guidelines for all agencies relevant to clients; and other issues faced by clients. It seems reasonable to assume that most, if not all of these could be addressed through collaborative training. However, respondents noted that while such efforts were encouraging, they were not common. These action statements were supported by the responses to the social services questionnaire, which noted the need for knowledge about

available services and the importance of such knowledge to making appropriate client referrals.

Communication and knowledge are also important given their relationship with trust and accountability. Trust, an essential building block of relationships, is broadly defined as one's confidence in another's capacity for honesty, integrity, reliability, and accountability. In order for an organization to be perceived as reliable and trustworthy, it must operate in a manner that is consistent with the expectations held by clients, other organizations, and the community. Given this, establishing reliability and trust are dependent upon the organization's ability to consistently communicate and fulfill its roles, responsibilities, and expectations, as well as consistency in applying eligibility criteria and service delivery. On the other hand, miscommunications regarding responsibilities and inconsistencies in fulfilling them are contrary to reliability and trust-building. Simply, trust is dependent upon the organization's ability to clearly articulate and fulfill its purpose. Each time an organization is successful in doing so, trust is strengthened and each time it is unsuccessful, trust is weakened (Vangen & Huxham, 2003). As examined in the literature review, trust is important to interorganizational relationships because it reduces the "need" for members to monitor one another (Reitan, 1998). The less effort an organization expends on monitoring other members, the more time and resources it has available for service delivery, relationship building, and fulfilling its obligations.

Trust and accountability are also negatively affected by the organizations' willingness to cooperate and service availability. Service providers are held accountable for fulfilling their roles and meeting the needs of their clients. Given that most clients have multiple needs that cannot be reasonably met by one organization, accountability requires organizations to work together. However, this is dependent upon each organization's willingness to fulfill its obligations to clients and to cooperate with other organizations. Unfortunately, all too often organizations are not committed to accountability and cooperation. In fact, many of the negative situations reported by respondents were related to these factors. For instance, respondents cited the

unwillingness of TDFPS to serve children who are over 10 years of age, especially teenagers, and the reluctance of schools to provide appropriate services to children identified as emotionally disturbed (ED). A possible explanation for a reluctance to cooperate is offered by resource dependence or power dependence theory, which proposes that an organization will only seek out relationships with other organizations if it views itself as dependent upon those relationships and/or is able to benefit from them (Raak & Paulus, 2001). Such a decision may also be made based on the degree to which the relationship will affect the organization's autonomy, goals, power, and activities. It is important to note that the current study did not yield explanations for the presence of these behaviors.

In terms of service availability, respondents noted that many of the services their clients needed either had limited availability or were not present in the community. Respondents tended to agree that limited service availability contributed to inappropriate utilization and overutilization of existing services. A common example was the overutilization of the juvenile justice system as a means to access services for clients and their families, especially mental health services. Although it does allow clients to access services, it results in the "criminalization" of youth who under more favorable circumstances would not be labeled as such. While respondents did not mention it, a similar situation occurs when parents relinquish their parental rights to the State in order to access mental health services for their child. Regrettably, there are approximately 250 such cases in Texas each year (MHAT, 2005). Other commonly mentioned service availability issues were related to mental health services (e.g., limited availability of psychiatrists, difficulty accessing inpatient psychiatric care, and wait periods for community based mental health services).

While these situations may result from a reluctance to cooperate and/or be held accountable, there are other viable explanations. First of all, service gaps are inherent in the current social services system for children. It is important to note that the results were consistent with the service gaps and related issues described in Chapter 2. Also, the current system limits services to those children who experience the most severe issues.

Furthermore, in many cases, eligibility for services does not guarantee receipt of such services. The system may also prevent the provision of necessary services. For example, a respondent noted that the RDM does not allow LMHAs to provide marriage therapy, even when it would benefit the child. Finally, the system and eligibility criteria tend to limit the ability of organizations to engage in cooperative efforts to assist clients who need additional services and/or are ineligible for services.

Interorganizational relationships are further affected by limited resources. Many organizations have experienced significant reductions in resources, especially funding. The response has been to restrict services to those who have the greatest need and avoid committing resources to endeavors that are not essential to the organization's survival. Often times this includes the avoidance of interorganizational relationships that are not directly beneficial to the organization, especially those that threaten the organization's autonomy, power, and goals. For instance, respondents reported that some school districts in the region do not allow service providers to meet with clients on campus during school hours. It is likely that this is related to the districts' emphasis on content mastery and performance exam pass rates. The aforementioned factors also affect organizational flexibility and their willingness to "think outside the box." For example, respondents reported that a lack of openness to new approaches occurred more than some of the time and was viewed as discouraging.

Despite the presence of factors that negatively affect interorganizational relationships, such relationships are present in the region. Respondents reported interorganizational relationships in the form of informal relationships and coordination. Examples of such include school systems that allow providers to see clients on campus during school hours, active CRCGs, local interagency councils, and joint service planning. Overall, respondents appeared pleased with these efforts, especially the CRCGs, which respondents characterized as a catalyst for collaboration, a vehicle for accountability, and a source of knowledge for available services. Respondents also tended to speak highly of the SNDP, a program resulting from state and local level partnerships. Respondents were especially pleased with the ability of the SNDP to create

relationships among providers, clients, and parents. In fact, CRCGs and the SNDP were commonly listed as "things to keep the same" and had the highest frequency and response ratings.

On the other hand, respondents identified the need to increase the quantity and quality of interorganizational relationships. This is supported by the go-zone for Service Delivery, which indicates that interorganizational relationships are encouraging, but are not frequently encountered (rated as very rarely to sometimes). Suggestions for changes included developing centralized service access points, centralized or coordinated assessments, common diagnostic criteria, and joint service planning. They also reported that while they possessed a basic knowledge of other agencies, it would be helpful to have specific information regarding policies, procedures, responsibilities, and services. Such information may be helpful in maintaining mutual respect, a factor that was perceived as common and frequently encountered. Many of these issues could be addressed through cooperative training, an intervention that had a low rate of occurrence, but was viewed as positive by many of the respondents. Cooperative training and greater understanding of services may also alleviate the perceived unwillingness of organizations to deal with difficult cases, which reportedly occurred on a frequent basis and was viewed as discouraging. Improving the existing interorganizational relationships would also be contingent upon successfully addressing other related factors, such as power differences, communication, trust, accountability, availability of resources, leadership, structure, and service availability.

Availability of Services

The second cluster in the concept map is Availability of Services, which consists of 23 factors that impact service delivery. Although factors related to service availability were included with Service Delivery, the factors included in this cluster are much more specific. A thematic analysis of the statements yielded the following themes: transportation, geographic boundaries, service providers, out-of-home placements, and community-based services. It is also important to note that Availability of Services was

ranked highest in every group comparison for the frequency rating scale. The only exceptions to this were the comparisons for residents of large and small counties and employees in large and small counties. Another interesting result was the tendency for statements to be perceived as occurring more than some of the time and discouraging at best. The rating scores suggest that all of the factors in this cluster could be considered barriers to collaboration and/or service delivery.

A common concern among respondents was client access to adequate and reliable transportation. Narrative responses indicated that many clients are unable to access services on a regular basis due to a lack of transportation. Clients who do not have access to a vehicle are especially disadvantaged. Most of the towns in the region do not have a public transportation system and those that do, have a limited system. Specifically, the routes are restricted to the city limits, leaving those who reside in the unincorporated areas of the county without service. The route times and proximity of the routes to services may also create barriers. Although access to a vehicle is helpful, in many cases the distance clients have to travel in order to receive services and the lack of service providers within close proximity to rural areas often prove to be troublesome. This is further confounded by agency policies, which often restrict or prohibit staff from transporting clients.

Respondents also included a variety of other factors related to the availability of services in the region, including the limited number of service providers, absence of out-of-home placements, and lack of various community-based services. In terms of the number of service providers, respondents simply noted that there were not enough providers to meet the need for services. As noted earlier in this dissertation, this is a common occurrence in rural areas that can be linked to a variety of factors including salaries and a desire to reside in a rural area. As for out-of-home placements, there are a limited number of RTCs in the region. The region does not have an inpatient crisis stabilization unit or an inpatient psychiatric hospital for children. The closest inpatient psychiatric facilities for children are located in Tyler, Texas and Humble, Texas. Depending on one's location in the region, these facilities are approximately 75 to 150

miles away. More importantly, clients without a third party payer source (private insurance or Medicaid) must go to Austin State Hospital (ASH), which is approximately 200 to 300 miles away. Respondents noted the need for more inpatient psychiatric beds, runaway shelters, a regional inpatient psychiatric stabilization unit, and additional RTCs. It is important to note that factors related to the lack of out-of-home placements had some of the highest frequency scores for this cluster, especially the lack of out-of-home placements for clients who are not eligible for juvenile detention or psychiatric hospitalization (4.05).

Respondents identified a variety of services that were either underrepresented or absent from the region, including support services, in-home services, aftercare services, crisis intervention services, and prevention/early intervention programs. Support services tended to focus on the family and included parenting classes, parent support groups, and respite care. Another commonly mentioned service was in-home services for clients, parents, and families. Respondents also recognized the need for community-based aftercare services to support clients returning to the community from an out-of home placement, such as an RTC, psychiatric facility, foster care, and TYC. In fact, several respondents recommended that aftercare services be provided via a comprehensive caseworker system. Other recommendations included the provision of support services to children who age out of the foster care system and school-based prevention and early intervention programs. In fact, the lack of prevention services had the highest frequency score for this cluster (4.16).

Organizational Factors

The third cluster in the concept map is Organizational Factors, which consists of 13 factors that impact service delivery. There was a very strong inverse correlation between the two rating scales (r = -.81), indicating that the more frequently a factor was encountered, the less encouraging it was perceived as being. In fact, all but one of the statements were rated as occurring at least some of the time and perceived as being somewhat discouraging at best. These scores suggest that all but one of the factors are

barriers to collaboration and/or service delivery. A thematic analysis of the statements yielded the following themes: staffing issues and factors that interfere with service delivery.

Specific issues related to staffing included high turnover, low wages, high emphasis on paperwork, understaffing and lack of appropriately trained staff. Not surprisingly, low wages was the most frequently encountered factor and the most discouraging. As for the factors that interfere with the delivery of services, the common theme appeared to be a lack of time for service delivery. More specifically, respondents felt that they were unable to spend an appropriate amount of time with each client. The barriers to doing so included the emphasis on paperwork and high caseloads. In fact, both of these factors were encountered sometimes to most of the time and perceived as discouraging at best. Several respondents suggested increasing funds in order to achieve adequate staffing patterns. Interestingly, all of the aforementioned factors are identified in the literature as barriers to forming and maintaining interorganizational relationships, especially in rural areas.

Public Schools and Public Awareness

The fourth cluster in the concept map is Public Schools and Public Awareness, which consists of 13 factors that impact service delivery. As with Organizational Factors, the majority of the items in this cluster were rated as occurring at least some of the time and perceived as being somewhat discouraging at best. Furthermore, there was a moderate inverse correlation between the two rating scales (r = -.48), suggesting that the more frequently a factor was encountered, the less encouraging it was perceived as being. The rating scores suggest that all but one of the factors are barriers to collaboration and/or service delivery. A thematic analysis of the statements yielded the following themes: lack of school-based services, communication, relationships among providers, advocacy, and public awareness.

As discussed in the previous sections on Service Delivery and Availability of Services, a common concern was the lack of school-based services. Respondents noted

the need for more services for students identified as Learning Disabled (LD), ED, and/or at-risk. Several of the negative situations identified in the narrative responses involved the reluctance of school districts to provide special education services to eligible clients. The narrative responses also indicated concern regarding the lack of school-based prevention and early intervention programs. The perceived reluctance to offer required services, as well as prevention and early intervention, is most likely due to limited resources, especially in the smaller and/or poorer school districts. Some assistance is available via the County School Co-ops, but their resources are limited as well.

Respondents also expressed concern regarding the tendency of schools to limit or deny service providers' access to clients during school hours. As previously noted, this is most likely due to the pressure exerted on school districts to comply with State expectations for performance exams. Unfortunately, many clients are unable to attend appointments with service providers during normal business hours. There are a variety of reasons for this, including parents who are unable to miss work, transportation issues, and/or uninvolved parents. For these clients, meeting with their provider at school is the best way to ensure continuity of services and maintain stability. In fact, the ability to meet with clients at school was appreciated by those who were provided such opportunities and viewed as a negative situation by those who did not have access.

Another related concern was the perceived resistance of school districts toward communication and cooperation with other service providers and parents. Interestingly, the lack of communication between parents and the school districts reportedly occurred more often than not and was discouraging at best. It is important to note that the issues of communication and cooperation among service providers were also identified under Service Delivery. Finally, the cluster included items related to public awareness, the most common themes being the need for public education and advocacy. All of these items were encountered more often than not and were viewed as discouraging at best.

Families

The fifth cluster in the concept map is Families, which consists of 14 factors that impact service delivery. All of the items in this cluster were rated as occurring at least some of the time and perceived as being somewhat discouraging at best. Interestingly, there was a very strong inverse correlation between the two rating scales (r = -.80), suggesting that the more frequently a factor was encountered, the more discouraging it was perceived as being. The rating scores suggest that all of the factors in this cluster are barriers to collaboration and/or service delivery. A thematic analysis of the statements yielded the following themes: client and family involvement; change potential; and public and legislative awareness.

Many of the service providers who participated found the lack of involvement of clients and parents discouraging. The ratings and narrative responses indicated a desire for more involvement, follow through and accountability from parents, especially with court-ordered services. Whereas several respondents suggested stiffer penalties for parents who are not active in their child's treatment, others recognized barriers to parent involvement and suggested possible solutions. For example, several respondents suggested addressing transportation issues via in-home services, such as those provided to SNDP clients. However, because such services are resource intensive, especially in terms of staff, time, and money, they are not a viable solution for many organizations. This cluster also included factors related to the awareness of families, legislators, and the general public about mental health disorders and services. These factors were encountered more often than not and perceived as discouraging, suggesting the need for more public education.

Funding

The sixth cluster in the concept map is Funding, which consists of 17 factors that impact service delivery. The majority of the items in this cluster were rated as occurring at least some of the time and perceived as discouraging at best. Not surprisingly, funding was ranked lowest in every group comparison for the response rating scale and concerns

about funding were present across respondent categories (parents, direct service providers, administrators, juvenile probation, and mental health). Furthermore, there was a moderate inverse correlation between the two rating scales (r = -.47), suggesting that the more frequently a factor was encountered, the less encouraging it was perceived as being. The rating scores suggest that all of the factors are barriers to collaboration and/or service delivery. A thematic analysis of the statements yielded the following themes: payment for services, community funding, unfunded mandates, government funding, and adequacy of services. These themes are also found in the narrative responses. In fact, funding for services is a theme that is common across the responses for all five of the narrative questions.

One of the key concerns regarding funding is the ability of clients to pay for services. Although services provided by TDFPS, LMHAs, juvenile probation, and school districts are free to those who qualify, many either do not qualify or require additional services that may not be free. For example, a child may qualify for mental health services through the LMHA, but he/she will have to wait until there is an opening. If a client in this situation were to seek services elsewhere, chances are he/she would be responsible for payment. An exception would be if he/she had third party mental health coverage, such as Medicaid or private insurance, and could find a provider who accepted the coverage. Unfortunately, most clients who rely upon the LMHA for services are unable to afford a private provider. There are several reasons for this, including the lack of mental health parity, the expense of private insurance, and/or the financial burden created by out-of-pocket costs for mental health services. Furthermore, there are very few private mental health care providers, especially psychiatrists, in the region. Thus, even those who have financial resources may have difficulty accessing private mental health services. Given this, the following recommendations from participants are reasonable: increase funding to help families without payer sources, increase the availability of indigent care services, and provide assistance to those who are underinsured.

As discussed in Chapter 2, Federal and State funds for state social services have been systematically cut over the past decade or so, resulting in an emphasis on intervention with the most difficult or severe cases. This is especially true for community and inpatient mental health services, as well as prevention and early intervention services. It is important to note that respondents sorted a related item under Public Schools and Public Awareness, which speaks to the perceived disconnect between funding streams and client needs. A common concern regarding funding for services involved the lack of funds for long term out-of-home placements, such as RTCs and inpatient psychiatric facilities. Currently, only TDFPS and juvenile probation departments have funds for RTC placements and in most cases, these resources are limited. The State's recent decision to limit TYC commitments to juveniles who have been adjudicated for a felony offense has heightened this concern. Specifically, local juvenile probation departments now have financial responsibility for out-of-home placements for misdemeanor offenders who are not able to remain in the community. In all likelihood, the condition of clients who are in need of an out-of-home placement and do not receive it will decline, resulting in more restrictive placements than originally necessary and greater costs to the community.

In addition to narrowing eligibility criteria and reducing services, funding reductions have threatened the adequacy and quality of services. Many of the related factors were included in Organizational Factors (i.e., employee turnover, low wages, emphasis on paperwork, understaffing, high caseloads and staff training). Furthermore, they have placed greater responsibility on local communities for meeting the needs of their residents. This includes the operation of CRCGs, which were created by an unfunded state mandate. As previously noted, most of the communities and counties in the region do not possess a tax base capable of supplementing state sponsored social services and unfunded mandates.

In response to the funding issues, respondents recommended a variety of actions, including: increasing local, state, and federal funding for public social services; increasing funds for preventative services; and increasing funds for organizational

operations, including staffing. However, the majority of the responses to the final question on the social services questionnaire indicated that overall respondents perceived changes to the current system, including funding, as extremely difficult, if not impossible. The common barriers to change were financial resources, bureaucracy, government, and resistance to change. Interestingly, these are all identified in the literature as barriers to forming and maintaining interorganizational relationships. In the context of rural areas, the lack of resources may encourage self-interest, which is especially damaging to interorganizational relationships (Snavely & Tracy, 2000).

Limitations

Regardless of the amount of thought and effort devoted to designing and implementing a study, there are always limitations. Given that limitations are expected, it is important to honestly identify them and their implications. In doing so, the audience is provided with the information necessary to make an informed decision regarding application of the findings. In terms of the current study, there are several limitations related to sampling and methodology, both of which are discussed below.

Sampling and Participants

Participants were chosen using a nonprobablity, purposive sample, which was expected to generate between 120 and 180 participants. However, the loss of two meeting sites and limited interest in the study resulted in a total of 20 focus group participants, 20 participants for sorting, and 44 participants for rating. Specific concerns regarding participants are outlined below.

- Focus Groups- Seventeen of the twenty focus group participants were service providers, the other three were parents of clients. Although the parents were from different counties, there were not enough parents to constitute a representative sample. Of the twenty participants, all but three were Caucasian, which does not match the service population. While there was some variety among service providers in terms of employer, there was only

one school district employee. Administrators and supervisors were also underrepresented. Finally, fourteen of the twenty participants represented larger counties. In summary, the following groups were underrepresented in the focus groups: parents, ethnic minorities, school district employees, administrators, supervisors, and representatives from smaller counties.

- Sorting- Only one of the twenty participants was a parent of a client; the rest were service providers. Of the twenty participants, only three were members of an ethnic minority group (two African Americans and one Native American). Seven of the twenty represented smaller counties in the region. In terms of employers, juvenile probation departments were well represented. However, there were only two LMHA employees, three DFPS employees, and two school district employees. As with the focus groups, administrators and supervisors were underrepresented. In summary, the following groups were underrepresented in the sorting process: parents, ethnic minorities, smaller counties, LMHAs, DFPS, school districts, administrators and supervisors.
- Rating- Of the forty-four participants who rated action statements, only three were parents of clients. While there was a greater representation of ethnic minorities, it was limited (nine participants). There was a better balance between large and small counties, 24 and 18, respectively. There was an equal representation of LMHA and DFPS employees (twelve each), yet school districts continued to be underrepresented. Administrators and supervisors were also underrepresented. In summary, the following groups were underrepresented in the rating process: parents, ethnic minorities, school district employees, administrators and supervisors.

Although the lack of representation for several key stakeholder groups affects the generalizability of the results to the region, the number of participants involved in each of the steps exceeded the minimum requirements for Concept Mapping. For example, the sorting process requires a minimum of ten participants and the current study involved twenty. The adequacy of this number is further supported by the concept map's stress

value of .26611, which falls within the acceptable range of 1.5 to 3.5 and below the average range of .27 to .30 (Trochim, 1993).

Methodology

While Concept Mapping is a very useful tool for planning and implementing change in service delivery systems, the methodology can be difficult to implement, especially in rural areas. Specifically, it requires a significant time commitment from participants. For example, participants in the current study were asked to participate in two meetings that occurred approximately two weeks apart. The first meeting was a two-hour focus group and the second meeting was a four-hour session in which participants sorted and rated the statements. In order to encourage participation, the researcher engaged in preliminary recruitment efforts, clearly explained the importance of involvement, traveled to the local communities instead of having participants travel to a central location, provided refreshments at the first meeting, and provided lunch at the second meeting. Despite these efforts, participation rates were substantially lower than expected.

Although participant interest or lack thereof negatively impacted the number of participants, it is not the only culprit. For instance, the lack of involvement from service providers can also be attributed to employers' reluctance to allow them to participate during business hours, which would reduce the amount of time the service providers were involved in billable activities. A potential solution for similar situations in future research efforts is to employ Concept Systems Global in the data collection process. Concept Systems Global is an enhanced web-based version of the Concept Systems Core program, which was utilized in the current study (Concept Systems, 2008). The Global version addresses time and geographical constraints by allowing participants to generate, sort and rate focus statements via the internet. Yet, there are some potential concerns with the Global version. The first concern is security and ownership of the online database, which is hosted by Concept Systems, Inc. It is possible that this arrangement could raise concerns with an Institutional Review Board regarding security of the data.

Another concern is that Concept Systems Global uses an individual process instead of a group process to generate action statements. Given that the author's prior experience with Concept Mapping has been that discussions among focus group members often generate additional action statements, the individual process may not generate an exhaustive list of action statements. Finally, Concept Systems Global requires participants to have access to a computer with internet access. While this may not be a concern for service providers, it is likely to be of concern for consumers, especially in rural areas. Notwithstanding the aforementioned concerns, Concept Systems Global may be a viable solution given time and geographical constraints in rural areas.

There are other several potential limitations inherent in the Concept Mapping process, the first of which is related to the focus prompt. Specifically, if the focus prompt is not clearly stated and easily understood, the resulting action statements may be unrelated to the issue being investigated. While it is possible that some of the respondents did not understand the focus prompt, all of the resulting action statements appear to be directly related to the prompt. Furthermore, the action statements represent a wide variety of positive and negative factors related to interorganizational relationships and service delivery. However, given the previously mentioned concerns regarding stakeholder representation in the focus group process, it is possible that the list of factors is not exhaustive. Another potential concern is the development of the responses for the rating process, which are based on a Likert scale. When developing a Likert scale it is important to create an adequate number of discrete and unique category labels that include a neutral midpoint (Springer, Abell, & Hudson, 2002). Although the rating scales utilized in this study clearly meet this criterion, in hindsight it may have been beneficial to include a category labeled "Not applicable." This category would have been helpful to respondents because several of the factors were specific to a local community and therefore irrelevant to some of the participants. In such cases, most of the participants did not respond to the item. Finally, Concept Mapping only allows one to examine the relationships among concepts. The process does not always yield information that provides insight or understanding of the relationships and it does not allow one to

establish causality. However, in the current study an understanding of the relationships was aided by the discussions that occurred during the focus group meetings, the feedback provided during the interpretation session, and the responses to the social services questionnaire.

Implications

Texas' ability to address the needs of children with emotional/behavioral issues, especially in rural areas, is impacted by a variety of factors related to service fragmentation, lack of resources and the limited capacity of local communities. In rural areas, service delivery is impacted by additional factors, including but not limited to social and economical underdevelopment, limited resources, geographical barriers, isolation, and difficulty recruiting and retaining professionals. Based on the literature review and the results of the current study, a viable solution to the issues facing providers and recipients of children's service in Deep East Texas should involve developing and strengthening relationships among service providers. But, this is not enough to alleviate the problem. The solution must also include closing the "gaps" in the social services system through structural changes, expansion of eligibility criteria, addition of services and changes in funding patterns. Failure to address these issues will only exacerbate existing tensions among agencies and thwart attempts to develop relationships. Since the results of the current study have implications for both interorganizational relationships and service delivery in the Deep East Texas region, each will be discussed in a separate section. The discussions will also include implications for practice, policy, social work education and research. Finally, it is important to remain mindful of the limitations identified in the previous section when reviewing the implications.

Interorganizational Relationships

The majority of the interorganizational relationships related to children's services within the Deep East Texas region can be characterized as informal relationships (see Figure 1 in Chapter 2 for details). There are a few relationships based on coordination,

but these relationships can be difficult to develop and maintain due to their reliance on an existing network of providers. While services are available in the region, many of them are not immediately accessible due to a variety of the reasons discussed in Chapters 1 and 2. Therefore, much of the contact between organizations is informal, loosely structured, and based on relationships among front line workers. There is limited involvement from administrators, little to no cooperative training, and sporadic community level planning. The major drawback of informal relationships and coordination is their limited capacity to bring about systematic change. On the other hand, they do not require a significant amount of resources to maintain and can increase the quality and continuity of services.

Although they are few and far between, formal relationships do exist within the region. These relationships take the form of partnerships or collaboration and include CRCGs and SNDP. Another important formal relationship in the Deep East Texas region is the Rural East Texas Health Network (RETHN), a network of local and regional stakeholders created for the purpose of improving access to primary healthcare and behavioral healthcare services through the development of a regional integrated system of care (Cooper & Avant, 2006). The initial development of the network was supported by a Rural Health Network Planning Grant offered by the Office of Rural Health Policy (U.S. Department of Health and Human Services, Health Resources and Service Administration). The current membership consists of a variety of organizations from across the region, including but not limited to municipal and county law enforcement agencies, local hospitals, county governments, courts of law (city, justice of the peace, county, and district courts), and the local mental health authority.

Once the grant was awarded, the applicant organizations engaged in a variety of network development activities, including hiring a program director, conducting a comprehensive needs assessment of the region, strategic planning, identifying and recruiting the network's core membership, and creating a preliminary framework for network governance and operations. These activities were guided by a comprehensive needs assessment and a Concept Mapping project designed to inform the development of a regional five year strategic plan (Belanger, 2006; Cooper & Avant, 2006). Since the

summer of 2006, RETHN has experienced a number of success, including the development of a regional board of directors, creation of a local advisory board for each county, implementation of a uniform regional protocol for mental health crisis interventions, regional training opportunities, and noticeably improved relationships among stakeholders (Cooper, Avant, & Hall, 2007). The network has also advocated for state funding to support regional mental health crisis intervention services, including an inpatient crisis stabilization unit. Although the funding request is pending, the coordinated effort required for this activity is a significant accomplishment, especially given the previous quality of relationships among stakeholders and the limited resources within the region. Another indicator of success is the membership's willingness to absorb the network's operational expenses over the past year. During this time the network submitted a proposal for a three year Rural Health Network Development Grant through the Office of Rural Health Policy. The grant was awarded in March 2008 and funding will begin May 2008.

The formal relationships within the region are important because they can serve as a catalyst and foundation for the development of new relationships. They can also assist in the formalization of other relationships, in turn increasing the region's capacity for facilitating systematic change, creating additional services for clients, and increasing the efficiency of services. However, partnerships, collaborations, and service integration (see Figure 1 in Chapter 2 for details) require a substantial degree of commitment, formality, and sharing of resources, all of which are dependent upon the key components of interorganizational relationships. Specifically, the members must be able to build and maintain trust, effectively manage power and politics, develop and maintain a structure that ensures representation of relevant stakeholders, and recruit and retain competent leadership. Therefore, before discussing the implications for increasing the formality of the existing relationships, it is important to discuss the issues identified by respondents that are related to the key components of interorganizational relationships.

As discussed earlier in this Chapter, respondents noted the presence of relationships and a willingness to engage in these relationships. Yet, they also identified

a variety of concerns regarding communication, knowledge, accountability, and willingness to cooperate. Specific factors identified through the Concept Mapping process are presented in Figure 40 and Table 66. As noted in Chapter 2, all of these factors hinder the development and maintenance of trust, the bond or "glue" that holds relationships together. Thus, one of the first steps would be to engage in activities that address these concerns and build trust among the organizations. In terms of communication and knowledge, it would be beneficial for organizations to work together to organize meetings to discuss or "staff" common clients and engage in joint treatment planning. It would also be helpful to develop and offer training programs and materials designed to orient staff to the services available for their clients, as well as the policies, procedures, responsibilities and guidelines for their agency and the agencies relevant to their clients. It seems reasonable to assume the provision of such knowledge would reduce miscommunications and foster respect among various professionals and service providers. For instance, Snavely and Tracy (2000) found that as leaders work together, they form personal relationships, which foster trust and eventual commitment to the interorganizational relationship. Additional support for this assumption can be found in the recent successes of the RETHN (Cooper, Avant, & Hall, 2007) and other studies that focus on developing trust and understanding between law enforcement officers and social service professionals (Arthur, Sisson, & McClung, 1977; Fein & Knaut, 1986; Holmes, 1982; Powell, 1994; Roberts, 1978; Scales & Cooper, 1999; Treger, 1980, 1981).

Other concerns related to trust included the perception that some organizations were unwilling to be held accountable and to work cooperatively with other organizations. Unfortunately, the current study did not yield explanations for the presence of these behaviors, leaving one to speculate about the potential reasons. As suggested earlier, it is possible that organizations are being held to expectations that are inconsistent with their true responsibilities and/or are unreasonable given the current constraints to service delivery, such as limited resources, eligibility criteria, and barriers to service delivery in rural areas. This situation mirrors one that American politicians often find themselves in,

> Americans hold a singular belief in the potency of leaders. We look to them –the "wise men"– to solve our problems. We want them to tell us what they will do before we elect them. Unfortunately, this creates unfulfillable expectations of leaders and, more significantly, provides an escape from responsibility for those of us not anointed as leaders. When leaders fail, we blame them rather than engaging ourselves in the difficult work of public policy problem solving. We expect quick fixes to complex problems. If all else fails, we "light out for the Territory", like Huck Finn, to escape responsibility (Chrislip & Larson, 1994, p. 34).

Assuming that the underlying issues are related to unrealistic and/or inconsistent expectations, joint organizational trainings and public education would be viable solutions.

It is also possible that organizations are truly unwilling to work cooperatively and be held accountable, both to themselves and to one another. On a positive note, reluctance to work together can be overcome by creating trust through small, simple, and successful activities (Chrislip & Larson, 1994; Vangen & Huxham, 2003). Examples of such include the joint staffings and trainings discussed earlier in this section. Each joint venture that results in success builds the trust among those involved and encourages additional ventures, which in turn provide additional opportunities to build trust and so on (Vangen & Huxham, 2003). In addition to overcoming reluctance to work cooperatively and be held accountable, trust is a catalyst for network formation. It serves to strengthen the network, assists in network maintenance, and reduces the "need" for members to monitor whether or not other members are fulfilling their responsibilities (Chrislip & Larson, 1994; Lackey et al., 2002; Reitan, 1998; Vangen & Huxham, 2003). Finally, because the potential explanations offered for the unwillingness to be held accountable and to work cooperatively are speculative, additional research on this topic would be beneficial in developing an understanding of the specific factors that drive these behaviors, especially in the Deep East Texas region.

Once the aforementioned trust related issues are addressed, the region could move forward with activities designed to build relationships that would strengthen its ability to address issues related to structure, resources, and service delivery. While the results of this study do not have specific implications for relationship building, other than those previously noted, it is important to briefly touch on this topic because of the implications for the relationships' capacity to bring about change. In addition to trust, successful relationships are dependent upon effective management of power and politics, a structure that ensures representation of relevant stakeholders, appropriate leadership, and a proactive response to the various barriers to collaboration. Clearly this is a difficult endeavor, especially given the barriers to rural service delivery, the underlying issue of funding, and the need for structural changes in state level agencies. Specific information regarding the design and implementation of such endeavors can be found in numerous sources, including Chrislip and Larson (1994), Poole (2002), and Vangen and Huxham (2003). For example, Poole (2005) discusses specific strategies for rural community-building. In fact, Poole's (2005) Community Partnership Model was instrumental in the design and implementation of RETHN.

Although RETHN primarily focuses on services for adults, there are many parallels between the issues faced by providers of adult services and providers of children's services. For instance, both groups face service fragmentation, lack of resources and the limited capacity of local communities. Given that members of RETHN face similar issues and provide services in the same region examined in this study, it seems reasonable that the basic activities RETHN employed would prove successful for local providers of children's services. Specifically, they could engage in a collaborative needs assessment, which would help them agree on a common definition of the problem, identify common goals, and develop a collective plan to guide their progress. The current study could serve to inform this process, but given its limitations, especially in terms of the sample, it should not be the sole source of information. Engaging in such activities could foster trust, cooperation, and accountability. It could also increase the region's capacity to collectively advocate for resources, services, and changes in policy. In terms

of a framework for these activities, providers of children's service have a unique benefit in that they are familiar with provider networks through their experiences with CRCGs and SNDP. In fact, these relationships could easily serve as a foundation for a larger provider network. They could also serve as a vehicle to address the issues respondents equated with CRCGs and SNDP, such as the impact of state control upon local autonomy, the effect of state level relationships and dynamics on local relationships, and the lack of resources to support activities of the CRCGs. However, addressing these issues is a difficult endeavor, especially given the barriers to rural service delivery, the underlying issue of funding, and the need for changes in structure and policies of state social service agencies.

In summary, the results of this study have several key implications for the development and maintenance of interorganizational relationships in the Deep East Texas region. First of all, current relationships could be strengthened via activities designed to address concerns with communication, knowledge, and accountability. Such activities would also build trust among organizations, which will strengthen current relationships and encourage future joint endeavors. However, successful relationships are also dependent upon the alleviation of barriers created by agency and state policy, such as funding issues and service "gaps" created by eligibility criteria. For instance, the development of a network requires resources for staffing and coordinating network activities. Much of RETHN's initial success is due to the efforts of its Director, whose employment was supported by the Rural Health Network Planning Grant. While the region supported the network after the first grant ended, it is doubtful that the region would have been willing or able to provide the financial support needed to start the development process. As previously discussed, future studies should focus on developing an understanding of the apparent resistance to accountability and cooperation, as well as gathering more information about the perceptions of parents and personnel from the local independent school districts. Finally, a clear implication for social work education is to ensure that students are exposed to theories and knowledge related to the development and maintenance of interorganizational relationships. Specific attention

should be given to the role of leaders in these relationships, especially the development of skills relevant to "managing out" (see Chapter 2). Since many of the BSWs in the Deep East Texas region tend to move into management positions within the first couple of years of practice, the aforementioned content is relevant to BSW and MSW curriculums.

Service Delivery

Although interorganizational relationships serve an imperative role in resolving the issues faced by the current children's social services system, there are other important and necessary components. Specifically, services should have a seamless structure, meaning the absence of service "gaps" and duplications. Services should also be consistent with client needs and regional issues, as well as adequately funded. As previously discussed in Chapters 1 and 2, service "gaps" are inherent in the current social services system. A brief overview of the current system and its issues follows:

- Juvenile Probation- Eligibility criteria exclude children under the age of 10 who present with significant conduct issues and those over 10 years of age whose conduct does not constitute a status offense (CINS) or criminal offenses. Those who aren't eligible may be referred to community mental health services, CPS, and/or school based services. Unfortunately many of them do not receive services until their behavior warrants formal attention from the juvenile justice system.
- Child Protective Services (CPS)- CPS is charged with serving children up to 17 years of age who are abused or neglected. However, there is a noticeable tendency to defer children 10 years and older, whose behaviors are related to inadequate supervision, to the juvenile justice system. Juvenile probation departments are unable to address such issues unless the behavior constitutes either CINS or delinquent conduct, whereas it is within the scope of CPS to address such behaviors.
- Mental Health Authorities (MHA)- The local MHA is responsible for serving children and adolescents who meet the "priority population" criteria. Due to

reductions in services and resources, children who qualify for services may have to wait up to a year for an opening. Children who are not eligible must either find other services in the community or go without services, placing them at-risk of involvement with other systems, such as juvenile justice.

- School Districts- Primary and secondary schools are mandated to provide special education services in the least restrictive environment to children who are identified as Emotionally Disturbed (ED).

Simply, the current system limits services to those children who experience the most severe issues and even those who qualify for services may have to wait up to a year to receive those services. Furthermore, individuals who are ineligible for services and are unable to afford private care, find themselves in a situation where they must get worse before they are able to access services. Participant responses, especially to the social services questionnaire, are consistent with the above description and the information provided in the literature review.

The information presented to this point suggests that the current service delivery system needs to be revamped to close the service "gaps" and expand the service population to include individuals who are either at-risk or are beginning to present emotional/behavioral issues. However, a difficult question remains unanswered. How should the system be changed? As discussed in Chapter 2, one of the common models for addressing the identified issues is systems of care. The model focuses on providing support to clients through a seamless service delivery framework that includes the following: mental health services, social services, educational services, health services, substance abuse services, vocational services, recreational services, and operational services (juvenile probation, case management, and support services (Stroul & Friedman, 1996). As discussed in Chapter 2, Texas has implemented four local systems of care as pilot programs through TIFI and evaluations indicated that the programs are beneficial to clients, as well as more cost-effective than residential treatment, a common alternative to community based treatment (MHAT, 2005; THHSC, 2007).

Despite the benefits and successes of the pilot systems of care programs, Texas has not moved toward adopting the model statewide. In fact, the state has not funded the four pilot projects since 2006 (THHSC, 2007). The absence of a specific reason(s) for the decision to terminate funding for the programs leaves one to speculation. It is very likely that some or all of the challenges faced by systems of care are at least partially responsible for this decision. Such challenges include time and resource requirements (development and maintenance); changes in leadership, staff, and political support with the passage of time; and the difficulty of balancing the goals, priorities, and policies of agencies and the system of care (Hernandez & Hodges, 2003). Also, a system of care's dependence upon collaboration makes it susceptible to the challenges of interorganizational relationships discussed in Chapter 2. Finally, implementing a system of care in Texas would require significant changes to current State and regional services and the development of new services. It would also require a financial commitment from the State legislature, which may not be likely given the decision to discontinue funding in 2006. However, it is possible to overcome some, if not all, of these issues through the development of regional interorganizational relationships.

In addition to addressing service delivery "gaps," organizations within the region may also need to examine issues specific to organizational structures and practices. For example, participants were concerned about accessibility issues, especially those created by transportation barriers. There are a variety of alternatives available to organizations, including satellite clinics, telehealth (videoconferencing), evening hours, and in-home services. While some of these solutions may not be financially feasible for agencies, especially smaller organizations, they could defray costs through cooperation and cost-sharing. Another key organizational issue was the perceived lack of time for service delivery, which could be related to other identified issues including high caseloads, emphasis on paperwork, staff turnover, and low wages. However, since Concept Mapping does not explain relationships, this would be a topic for future investigation. Finally, organizations should take the lead in conducting and encouraging research about challenges to service delivery and the issues facing their clients. This information could

assist in educating the general public and legislators with a goal of reducing the apparent disconnect between funding and social issues, increasing legislators' willingness to fund social services, and a greater understanding of mental illness.

In summary, the results of this study have several key implications for the delivery of services to children who are at-risk of or possess emotional/behavioral issues. First of all, the results are consistent with the issues of the current system described in Chapter 2, indicating the need for changes in the structure of services. The respondents' overall positive perception of current relationships and cooperative efforts are conducive to making such changes, including the implementation of a systems of care model. In addition to the implications for policy and funding discussed earlier, such an endeavor has implications for research and social work education. In terms of research, it would be wise to conduct a regional needs assessment to identify the specific strengths and needs of the region. Given the sample limitations of the current study, future investigators should take steps to increase the involvement of parents and school district employees, as well as to identify and include additional relevant stakeholders. It would also be beneficial to collect specific information regarding the costs associated with the delivery of services under the current model, which would allow for future cost analyses. Finally, a clear implication for social work education is to ensure that students are exposed to theories and knowledge related to the functioning and maintenance of larger systems, including government, social welfare policy, funding, legislative process, and interorganizational relationships. Specifically, the content should focus on developing their understanding of the impact macro system issues can have upon micro systems and how to address such issues. All too often social workers lose sight of the macro issues and forget to include them in their interventions, ensuring the larger issues will remain unresolved.

Conclusion

The dissertation sought to further the current understanding of the factors that impact interorganizational relationships and service delivery to children who possess or

at-risk of emotional/behavioral issues in the context of a 12 county region in East Texas. The study generated information about strengths, needs, and service "gaps," as well as specific factors that impact service delivery, such as communication, knowledge, trust, service availability, willingness to work together, funding, staffing issues, and public awareness. The majority of these factors are detrimental to service delivery, as well as efforts to develop and maintain interorganizational relationships. The identification of such factors allows for proactive problem-solving and planning, which is vital to implementing change in service delivery systems. In addition to having specific implications for the Deep East Texas region, the results of this study are important to the social work profession in that they provide information about the perceptions of rural service providers regarding barriers to service delivery and interorganizational relationships.

While the study does further the understanding of the issues facing the Deep East Texas region, it is only a starting place. Future research endeavors should include efforts to develop an understanding of issues contributing to organizational resistance to cooperation and accountability, the perceptions of parents and school district employees, the specific service needs of the region, and cost analyses of current services. This information will be vital to the identification and implementation of a solution, which appears to lie in closing the "gaps" in the current social services system through expansion of eligibility criteria, addition of services and changes in funding patterns. Failure to address these issues will only exacerbate existing tensions among agencies, thwart attempts to develop relationships, and interfere with the delivery of quality services to clients. Unfortunately, but not surprisingly, most of the participants believed that it would be difficult, if not impossible, to change the public social services system, citing money, bureaucracy, government, and/or resistance to change as the key barriers. Thus, the most important question seems to be whether Texan's will make a "Texas-sized" effort to address these problems or adopt Huck Finn's approach and seek an escape?

APPENDIX A- PARTICIPANT LETTER

Date

Participant Name
Participant Address
Participant Address

Dear Sir/Madam,

Thank you for your interest in participating in the study titled *Building and Maintaining Interorganizational Relationships Among Providers of Public Social Services for Emotionally Disturbed Children in Rural East Texas.*

As we discussed, the purpose of this study is to identify the factors that affect the abilities of service providers to build and maintain relationships with other organizations. We are also interested in client and service provider perceptions of current services. In order to ensure the information gathered is representative of the region served by the Deep East Texas Council of Governments, we are inviting service providers and parents/guardians of clients from Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler counties to participate in the study. We are hopeful that the information gathered during this study will inform future decisions about the delivery of services in the twelve county region served by the Deep East Texas Council of Governments. If you chose to be involved in the project, you will participate in two group sessions designed to identify, sort, rate ideas about public social services for children in East Texas. Six separate groups will be formed, one in each of the following towns: Center, Crockett, Jasper, Livingston, Lufkin, and Nacogdoches. Each group will meet on two separate occasions (see the details provided below). The sessions will be facilitated by Steve Cooper, who is certified as a Concept Systems Facilitator by Concept Systems, Inc, and Freddie Avant. An overview of the process is as follows:

1. ***Generation of Statements (Date and Location of Group Session)***- Each of the six groups will meet separately to generate a set of statements that represent factors that affect the ability of public social service providers to deliver services. Participants will also complete a questionnaire regarding their perceptions of public social services for children. Although the process will be facilitated by Steve Cooper and Freddie Avant, the participants will guide it and are ultimately responsible for the final list of statements.

2. ***Sorting & Rating of Statements (Date and Location of Group Session)***- Participants of the six focus groups will meet a second time to sort and rate all of the statements generated by the focus groups. The sorting process involves sorting the statements into conceptual domains and assigning labels to each of the statement groups created. The rating process involves completion of rating instrument consisting of the statements generated during the focus group meetings.

3. ***Representation of Statements (Late April to Late May)***- The researchers will enter the data into the concept mapping software, which will generate a concept map of the statements and identified domains. Specifically, multidimensional scaling and hierarchical cluster analysis will generate the map depicting the graphical relationships among and between the statements. The software will also sort them into domains or clusters based on statistical similarity. However, the software does not provide a mathematical solution for determining the final number of domains. Thus, the

researcher will make this decision based on an examination of the cluster mergers and conceptual understanding of the statements.

4. ***Interpretation (Late May to Early June)***- The researchers will meet with participants in order to solicit assistance with the interpretation the findings from the concept mapping process. These meetings will also provide an opportunity to discuss similarities and differences between the participants. The meetings will be scheduled at a later date.

Confidentiality

All precautions necessary to ensure the maintenance of confidentiality will be taken. All of the rating instruments, data, and related items will be stored at the Stephen F. Austin State University School of Social Work in a locked file cabinet. All computer data files will be stored on a secure computer that is not accessible via computer network. The aforementioned information will be maintained in its original form for the duration of the project and will then be destroyed by shredding. Only the researchers and research assistant will have access to the data. The final reports will consist of summary information without specific reference to individual participants. Steve Cooper & Freddie Avant will be available to participants both during and after the project to address questions and concerns.

Potential Risks & Benefits

The information being gathered is related to your perceptions of public social services for children who possess or are at-risk of emotional/behavioral issues, the sharing of which does not place you at foreseeable risk. Although participants will be asked demographic information, it will be solicited individually via the demographic information sheet. Since the questionnaire, sorting forms, and rating instruments will not contain identifying information and only the investigators will have access to the instruments and participant information, the risk of breeching confidentiality is minimal. Furthermore, participants will be advised that they are not required to complete the demographic information sheet or any of the other instruments. The final anticipated potential risk is the discomfort generated by discussing personal opinions in a group setting. It should be noted that the concept mapping process is designed to minimize such discomfort. It is expected that inclusion of all the stakeholders in the study will result in a comprehensive data set capable of informing future decisions regarding the delivery of public social services for children in rural East Texas.

Please RSVP for the meetings to Steve Cooper at (936) 468-2845 or scooper@sfasa.edu. Again, thank you for your interest in participating in this study.

Sincerely,

H. Stephen Cooper, LMSW
Assistant Professor of Social Work
School of Social Work
Stephen F. Austin State University

Ph.D. Candidate
School of Social Work
The University of Texas at Austin

APPENDIX B- CONSENT FORM

Title: Interorganizational Relationships Among Providers of Public Social Services for Emotionally Disturbed Children in Rural East Texas

Conducted By:

Principal Investigator
H. Stephen Cooper, LMSW, Ph.D. Candidate
School of Social Work
University of Texas at Austin

Assistant Professor
School of Social Work
Stephen F. Austin State University
Box 6104, SFA Station
Nacogdoches, Texas 75962
(936) 468-2845
scooper@sfasu.edu

Faculty Sponsor
David W. Springer, Ph.D.
Associate Dean for Academic Affairs
Professor, School of Social Work
University of Texas at Austin
1 University Station D3500
Austin, Texas 78712-0358
(512) 471-0512
dwspringer@mail.utexas.edu

You are being asked to participate in a research study. This form provides you with information about the study. The person in charge of this research will also describe this study to you and answer all of your questions. Please read the information below and ask any questions you might have before deciding whether or not to take part. Your participation is entirely voluntary. You can refuse to participate without penalty or loss of benefits to which you are otherwise entitled. You can stop your participation at any time and your refusal will not impact current or future relationships with The University of Texas at Austin, Stephen F. Austin State University, and current or future service providers. To do so simply tell the researcher you wish to stop participation. The researcher will provide you with a copy of this consent for your records.

The purpose of this study is to examine the delivery of public social services to children who are at risk of or possess emotional/behavioral issues. We are currently asking various stakeholders from Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler counties to participate in this study. You were chosen as a potential participant in our study because you were identified as either a service provider or parent/guardian of a current client.

If you agree to be in this study, we will ask you to do the following things:

- You will need to be available for two separate meetings, each lasting approximately 2 hours. If you agree to participate, you will need to be available for two separate meetings, each lasting approximately 2 hours. The group meetings will be held in the following towns: Center, Crockett, Jasper, Livingston, Lufkin, and Nacogdoches. You will have the ability to choose the location most convenient for you.
- During these meetings you will work with a group of other participants to identify, sort, and rate various statements that represent factors that affect the ability of public social service providers to deliver services.
- Participants will also be asked to complete a questionnaire regarding their perceptions of public social services for children.

Total estimated time to participate in study is 4 hours.

Risks of being in the study include:

- The only anticipated potential risk is the discomfort generated by discussing personal opinions in a group setting. It should be noted that the concept mapping process is designed to minimize such discomfort.
- This process may involve risks that are currently unforeseeable. If you wish to discuss the information above or any other risks you may experience, you may ask questions now or call the Principal Investigator listed on the front page of this form.

Benefits of being in the study include:

- Your participation in this study is of particular benefit to our region, as it will assist with efforts to involve community members in improving the delivery of services to children who are at risk of or possess emotional/behavioral issues.
- It is also possible that the results of the project will assist other rural communities in their attempts to address similar situations

Compensation/Costs:

- There is no charge for your participation and you will not be compensated for your participation.

Confidentiality and Privacy Protections:

- No information collected will contain your name, address, or any other identifying information.
- Although some of the information gathered will be coded so that your responses can be matched, only the investigators will have access to the codes.
- The information you provide will remain confidential and will only be used when your identity is protected.
- If the results of this research project are published or presented at professional conferences or meetings, your identity will not be disclosed.
- The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation in any study.

The records of this study will be stored securely and kept confidential. Authorized persons from The University of Texas at Austin and members of the Institutional Review Board have the legal right to review your research records and will protect the confidentiality of those records to the extent permitted by law. All publications will exclude any information that will make it possible to identify you as a subject. Throughout the study, the researchers will notify you of new information that may become available and that might affect your decision to remain in the study.

Contacts and Questions:

If you have any questions about the study please ask now. If you have questions later, want additional information, or wish to withdraw your participation call the researchers conducting the study. Their names, phone numbers, and e-mail addresses are at the top of this page. If you have questions about your rights as a research participant, complaints, concerns, or questions about the research please contact Jody Jensen, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects at (512) 232-2685 or the Office of Research Support and Compliance at (512) 471-8871 or email: orsc@uts.cc.utexas.edu.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information and have sufficient information to make a decision about participating in this study. I consent to participate in the study.

Signature:_____ Date: _____

_____ Date: _____
Signature of Person Obtaining Consent

Signature of Investigator:_____ Date: _____

APPENDIX C- PARTICIPANT INFORMATION FORM

_____

All participants are asked to complete the questions in this section (questions 1 through 9):

1. Which group best represents your role for the purposes of this initiative? (please check only one)

☐ Parent/Guardian of a Client
☐ Service Provider
☐ Other _____

2. What is your race/ethnicity? (please check only one)

☐ African American/Black
☐ Asian American/Pacific Islander
☐ Latino/Hispanic
☐ Multiracial
☐ Native American
☐ White/European
☐ Other Group _____

3. What is your gender? ☐ Female ☐ Male

4. What is your current age in years? _____

5. What is your highest level of education? (please check only one)

☐ Less than a high school education
☐ High school education without a diploma
☐ High school diploma or GED
☐ Trade school/training program (completed)
☐ Some college, no degree
☐ Associate degree
☐ Bachelor degree
☐ Graduate/Professional degree

6. What is your primary county of residence? _____

7. What is your primary county of employment? _____

8. What is your average monthly household income? _____

9. Which group best represents your employment status? (please check only one)

☐ Full-time, with benefits
☐ Full-time, without benefits
☐ Part-time, with benefits
☐ Part-time, without benefits
☐ Seasonal or contract labor
☐ Unemployed
☐ Retired
☐ Other _____

Only parents/guardians are asked to complete the questions in this section (questions 10 through 17):

10. How many children do you have? (please include all children regardless of age and residence) ____

11. How many of the children reported in question #10 have been, at one time or another, involved with the following service providers? (check all that apply and place the number in the blank provided)

- ☐ Local Mental Health Authority _____
- ☐ Department of Family and Protective Services _____
- ☐ Special Education Services for Emotional Disturbance _____
- ☐ Juvenile Probation _____
- ☐ Other _____

12. How many children currently live in your home? (please only include children under 18 years of age) _____

13. How many of the children reported in question #12 are currently involved with the following Service providers? (check all that apply and place the number in the blank provided)

- ☐ Local Mental Health Authority _____
- ☐ Department of Family and Protective Services _____
- ☐ Special Education Services for Emotional Disturbance _____
- ☐ Juvenile Probation _____
- ☐ Other _____

14. How many of the children reported in question #12 are your grandchildren? _____

15. How many adults currently reside in your home? (please include all individuals 18 years of age and older) _____

16. How many of the adults reported in question #15 assist with the care of your children? (please include all individuals that supervise the children, assist financially, etc.) _____

17. Which of the following categories best describes your current marital status? (please check only one)

- ☐ Single, never married
- ☐ Married
- ☐ Married, but legally separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other _____

Only service providers are asked to complete the questions in this section (questions 16 through 22):

16. Which of the following categories best represents your current employer? *(please check only one)*

- ☐ Local Mental Health Authority
- ☐ Department of Family and Protective Services
- ☐ Independent School District
- ☐ Juvenile Probation
- ☐ Other _____

17. How many years have you been employed by your current employer? _____

18. Which group best represents your primary job duties? *(please check only one)*

- ☐ Front-line or Direct service provider
- ☐ Supervisor
- ☐ Administrator
- ☐ Other _____

19. How long have you been in your current position? (years/months) _____

20. How many years experience do you have in the delivery of social services to children? (total years/months) _____

21. Do you hold any of the following professional licenses? *(please check all that apply)*

- ☐ Attorney
- ☐ Clinical Psychologist
- ☐ FNP (Family Nurse Practitioner)
- ☐ LMFT
- ☐ LCDC
- ☐ LBSW
- ☐ LMSW
- ☐ LMSW-AP
- ☐ LCSW
- ☐ LPC
- ☐ LVN
- ☐ MD
- ☐ Occupational Therapist
- ☐ Peace Officer (TCLEOSE)
- ☐ Physical Therapist
- ☐ PA (Physician's Assistant)
- ☐ PA (Psychological Associate)
- ☐ RN
- ☐ Speech Pathologist
- ☐ Teacher
- ☐ Other _____

22. If you hold more than one professional license, which one is your primary license? *(please check only one)*

- ☐ Attorney
- ☐ Clinical Psychologist
- ☐ FNP (Family Nurse Practitioner)
- ☐ LMFT
- ☐ LCDC
- ☐ LBSW
- ☐ LMSW
- ☐ LMSW-AP
- ☐ LCSW
- ☐ LPC
- ☐ LVN
- ☐ MD
- ☐ Occupational Therapist
- ☐ Peace Officer (TCLEOSE)
- ☐ Physical Therapist
- ☐ PA (Physician's Assistant)
- ☐ PA (Psychological Associate)
- ☐ RN
- ☐ Speech Pathologist
- ☐ Teacher
- ☐ Other _____

APPENDIX D- SOCIAL SERVICES QUESTIONNAIRE

Please answer the following questions in the spaces provided.

1. Please describe a positive situation you were directly involved in during the course of delivering/receiving public services for children who possess or are at-risk of emotional/behavioral issues. _____

2. Please describe a negative situation you were directly involved in during the course of delivering/receiving public services for children who possess or are at-risk of emotional/behavioral issues. _____

3. If you were involved in changing public social services for children who possess or are at-risk of emotional/behavioral issues, what is one thing that you would change? Please explain your answer

4. If you were involved in changing public social services for children who possess or are at-risk of emotional/behavioral issues, what is one thing that you would keep the same? Please explain your answer.

5. In your opinion, how easy or difficult would it be to change the current public social services system for children who possess or are at-risk of emotional/behavioral issues? Please explain your answer.

APPENDIX E- FOCUS GROUP SESSION INSTRUCTIONS

The purpose of this study is to identify the factors that affect the ability of service providers to build and maintain relationships with other organizations. We are hopeful that the information gathered during this study will inform future decisions about the delivery of children's services in the twelve county region served by the Deep East Texas Council of Governments.

The purpose of the focus group session is to generate statements (short phrases or sentences) that describe specific factors that impact the ability of public social service providers to work together in the delivery of services to clients who possess or at-risk of emotional/behavioral issues and their families. The session will begin with each of you recording three specific ideas in the space provided below. Please keep the following guidelines in mind:

- Try to give us ideas that are specific or operational, rather than "big picture". We want to know what your ideas are from your own point of view.
- Please suggest ideas that might be different from the "same old thing."
- Please try to think of both ***positive*** factors (things that help build new relationships or that maintain current relationships) and ***negative*** factors (things that prevent the creation of relationships or that interfere with current relationships).

Once you have recorded three ideas, the group will discuss the statements and select approximately 20 statements to be included in the sorting and rating stages of the process. While the facilitator will provide additional instructions, please keep the following ground rules in mind:

1. The focus needs to remain on the task at hand.
2. Any input addressing the task is ok.
3. The ideas and opinions of the group members are to be respected. While questioning for clarification is acceptable, criticism is not.
4. Statements will not be edited, except for clarity and form consistency.
5. Please listen to others.

Focus Prompt

One factor that impacts the ability of public social service providers to work together in the delivery of services to clients and their families is…

1.

2.

3.

APPENDIX F- SORTING & RECORDING INSTRUCTIONS

Step 1- Sorting the Task Statement Cards. You have been provided with a set of cards. Each card has a statement and an ID number. We would like you to *group the statements into piles in a way that makes sense to you*, following theses guidelines:

- Group the statements for how similar in meaning they are to one another. Do not group the statements according to how important they are, how high a priority they have, etc. Another part of the process will ask you how important you believe each statement is.

- There is no right or wrong way to group the statements. You will probably find that you could group the statements in several sensible ways. Pick the arrangement that feels best to you.

- You cannot put one statement into two piles at the same time. Each statement must be put into only one pile.

- People differ on how many piles they end up with. In most cases, anywhere from 10 to 20 piles usually works out well.

- A statement may be put alone as its own pile if you think that it is unrelated to all the other statements or it stands alone as a unique idea. **Do not** have any piles of "miscellaneous" statements.

- Make sure that **every** statement is put somewhere. Do not leave any statements out.

Step 2- Recording the Results. You also have a **Sort Recording Sheet** for recording the results of your groupings. On this sheet, please write the results as described below. .

- Pickup any one of your piles of statements. It does not matter what order the piles are recorded in.

- Quickly scan the statements in this pile and write down a *short phrase or title* that describes the contents of the pile on the line provided after ***Pile Title or Main Topic*** in the first available box on the Sort Recording Sheet.

- In the space provided under the pile name, write the statement identification (ID) number of each card in that pile. Separate the numbers with commas. When you finish with the pile, put it aside so you don't mistakenly record it twice.

- Move on to your next pile and repeat the three steps above, recording the statement numbers in the next available box on the Sort Recording Sheet. Continue in this way until all your piles have been named and recorded.

- Your Sort Recording Sheet has room for you to record up to 20 piles or groups of cards. As mentioned above, any number of piles (usually 10 to 20) is fine. If you have more than 20 piles, continue recording your results on a blank sheet of paper and be sure to attach this extra sheet to the ones provided.

- ***Please write legible and clearly.*** Most of the errors that find their way into the program and results are made at this stage and are due to data that is hard to read.

APPENDIX G- SORT RECORDING SHEET

This sheet is to be used for recording the results of your sorts. Remember that you do not have to have as many piles as there are boxes on this sheet. The space is provided to allow for variability among participants in the way they group the items. The first box (Example Pile) is filled out to serve as a guide for you.

Example Pile Title or Main Topic: *Program Management*

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

1, 4, 29, 43, 12

Start recording your sorts here:

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _____

Record here the identifying number of each item in this pile, separating the ID numbers with commas.

APPENDIX H- FREQUENCY RATING SHEET

Frequency Rating Sheet

Interorganizational Relationships Study

_____

How often have you experienced this factor while delivering/receiving services?

1 = None of the time; 2 = Very rarely; 3 = Some of the time; 4 = Most of the time; 5= All of the time

☐1 ☐2 ☐3 ☐4 ☐5	**1.**	the tendency of service providers to not look outside the box for possible answers or solutions to client issues
☐1 ☐2 ☐3 ☐4 ☐5	**2.**	the limited number of service providers for clients
☐1 ☐2 ☐3 ☐4 ☐5	**3.**	the limited number of local out-of-home placements for clients
☐1 ☐2 ☐3 ☐4 ☐5	**4.**	the high number of at-risk students compared to the limited time available to serve them
☐1 ☐2 ☐3 ☐4 ☐5	**5.**	the high number of at-risk students compared to the limited resources available to serve them
☐1 ☐2 ☐3 ☐4 ☐5	**6.**	the willingness of the client to participate with service providers
☐1 ☐2 ☐3 ☐4 ☐5	**7.**	the willingness of the client's parents to participate with service providers
☐1 ☐2 ☐3 ☐4 ☐5	**8.**	the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions
☐1 ☐2 ☐3 ☐4 ☐5	**9.**	limited access to client transportation
☐1 ☐2 ☐3 ☐4 ☐5	**10.**	current collaborative efforts via Community Resource Coordination Group (CRCG)
☐1 ☐2 ☐3 ☐4 ☐5	**11.**	current collaborative efforts via CASA (Court Appointed Special Advocates)
☐1 ☐2 ☐3 ☐4 ☐5	**12.**	current collaborative efforts via Nacogdoches Safe and Drug Free
☐1 ☐2 ☐3 ☐4 ☐5	**13.**	the client's ability to pay for services
☐1 ☐2 ☐3 ☐4 ☐5	**14.**	the lack of access to service providers within close proximity to rural areas
☐1 ☐2 ☐3 ☐4 ☐5	**15.**	service providers' limited familiarity with services
☐1 ☐2 ☐3 ☐4 ☐5	**16.**	families' limited familiarity with services
☐1 ☐2 ☐3 ☐4 ☐5	**17.**	the lack of follow through with services from families
☐1 ☐2 ☐3 ☐4 ☐5	**18.**	the lack of follow through with services from professionals

How often have you experienced this factor while delivering/receiving services?

1 = None of the time; 2 = Very rarely; 3 = Some of the time; 4 = Most of the time; 5= All of the time

☐1 ☐2 ☐3 ☐4 ☐5	**19.**	the unwillingness of Medicaid to provide comprehensive coverage to clients
☐1 ☐2 ☐3 ☐4 ☐5	**20.**	the lack of consequences for parents who are not actively involved in services for their children
☐1 ☐2 ☐3 ☐4 ☐5	**21.**	the lack of support groups to help parents develop the skills they need to help their child
☐1 ☐2 ☐3 ☐4 ☐5	**22.**	the lack of community-based mentors to work with the child and service providers
☐1 ☐2 ☐3 ☐4 ☐5	**23.**	the lack of school-based mentors to work with the child and service providers
☐1 ☐2 ☐3 ☐4 ☐5	**24.**	current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)
☐1 ☐2 ☐3 ☐4 ☐5	**25.**	the lack of school-based resources to serve children identified as LD (learning disabled)
☐1 ☐2 ☐3 ☐4 ☐5	**26.**	the lack of school-based resources to serve children identified as ED (emotionally disturbed)
☐1 ☐2 ☐3 ☐4 ☐5	**27.**	the distances families have to travel in order to receive services
☐1 ☐2 ☐3 ☐4 ☐5	**28.**	the tendency of agencies to work against each other instead of together
☐1 ☐2 ☐3 ☐4 ☐5	**29.**	Memorandums of Understanding (MOUs)
☐1 ☐2 ☐3 ☐4 ☐5	**30.**	interagency staff meetings
☐1 ☐2 ☐3 ☐4 ☐5	**31.**	the lack of financial support available in the community to support service delivery
☐1 ☐2 ☐3 ☐4 ☐5	**32.**	the willingness of clients to make substantive changes recommended by service providers
☐1 ☐2 ☐3 ☐4 ☐5	**33.**	the willingness of parents to make substantive changes recommended by service providers
☐1 ☐2 ☐3 ☐4 ☐5	**34.**	the willingness of families to make substantive changes recommended by service providers
☐1 ☐2 ☐3 ☐4 ☐5	**35.**	the use of mutual (interagency) training sessions to clarify agency policies

How often have you experienced this factor while delivering/receiving services?

1 = None of the time; 2 = Very rarely; 3 = Some of the time; 4 = Most of the time; 5= All of the time

☐1 ☐2 ☐3 ☐4 ☐5	**36.**	the use of mutual (interagency) training sessions to clarify agency responsibilities
☐1 ☐2 ☐3 ☐4 ☐5	**37.**	the limited availability of services in the local community
☐1 ☐2 ☐3 ☐4 ☐5	**38.**	the tendency to rush to judge clients and their problems because of the opinions of entities involved with the clients
☐1 ☐2 ☐3 ☐4 ☐5	**39.**	decentralized client services
☐1 ☐2 ☐3 ☐4 ☐5	**40.**	centralized client services
☐1 ☐2 ☐3 ☐4 ☐5	**41.**	the lack of familiarity among service providers with the nature of rural areas
☐1 ☐2 ☐3 ☐4 ☐5	**42.**	reluctance of agencies to engage in staffings for common clients
☐1 ☐2 ☐3 ☐4 ☐5	**43.**	reluctance of agencies to communicate with one another
☐1 ☐2 ☐3 ☐4 ☐5	**44.**	the limited understanding of the policies of other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**45.**	the limited understanding of the procedures of other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**46.**	the limited understanding of the responsibilities of other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**47.**	the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)
☐1 ☐2 ☐3 ☐4 ☐5	**48.**	the high turnover rate of service providers
☐1 ☐2 ☐3 ☐4 ☐5	**49.**	the need for more home-based (in-home) services
☐1 ☐2 ☐3 ☐4 ☐5	**50.**	too much emphasis on paperwork
☐1 ☐2 ☐3 ☐4 ☐5	**51.**	the knowledge of available services
☐1 ☐2 ☐3 ☐4 ☐5	**52.**	the lack of community based aftercare services to support clients once they are released from an out-of-home placement
☐1 ☐2 ☐3 ☐4 ☐5	**53.**	the ability of agencies to work together to serve the client and family
☐1 ☐2 ☐3 ☐4 ☐5	**54.**	the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)
☐1 ☐2 ☐3 ☐4 ☐5	**55.**	the degree to which agencies will allow for creativity in working with clients and their families
☐1 ☐2 ☐3 ☐4 ☐5	**56.**	familiarity with the processes of other agencies involved with the client

How often have you experienced this factor while delivering/receiving services?

1 = None of the time; 2 = Very rarely; 3 = Some of the time; 4 = Most of the time; 5= All of the time

☐1 ☐2 ☐3 ☐4 ☐5	**57.**	mutual respect among agencies involved in delivering services to the client
☐1 ☐2 ☐3 ☐4 ☐5	**58.**	openness to the views of other agencies involved in delivering services to the client
☐1 ☐2 ☐3 ☐4 ☐5	**59.**	openness to the approaches of other agencies involved in delivering services to the client
☐1 ☐2 ☐3 ☐4 ☐5	**60.**	the ability of agencies to start where the client is
☐1 ☐2 ☐3 ☐4 ☐5	**61.**	the ability of service providers to start where the client is
☐1 ☐2 ☐3 ☐4 ☐5	**62.**	limited coverage of health insurance for mental health issues
☐1 ☐2 ☐3 ☐4 ☐5	**63.**	limited access to health insurance for clients
☐1 ☐2 ☐3 ☐4 ☐5	**64.**	the distance clients must travel to access services
☐1 ☐2 ☐3 ☐4 ☐5	**65.**	the lack of communication between the school district and parents
☐1 ☐2 ☐3 ☐4 ☐5	**66.**	the lack of cooperation between the school district and mental health service providers
☐1 ☐2 ☐3 ☐4 ☐5	**67.**	the limited amount of time allowed by school districts for mental health service providers to meet with clients
☐1 ☐2 ☐3 ☐4 ☐5	**68.**	the unwillingness of school districts to allow mental health service providers to meet with clients at school
☐1 ☐2 ☐3 ☐4 ☐5	**69.**	the lack of family therapy services for mental health clients
☐1 ☐2 ☐3 ☐4 ☐5	**70.**	the lack of parent involvement with their children
☐1 ☐2 ☐3 ☐4 ☐5	**71.**	the limited amount of time available per client due to service delivery expectations
☐1 ☐2 ☐3 ☐4 ☐5	**72.**	the lack of local funding for mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**73.**	the lack of state funding for mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**74.**	the lack of federal funding for mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**75.**	shorter stays for inpatient psychiatric services
☐1 ☐2 ☐3 ☐4 ☐5	**76.**	limited Medicaid coverage for inpatient psychiatric services
☐1 ☐2 ☐3 ☐4 ☐5	**77.**	limited insurance coverage for inpatient psychiatric services
☐1 ☐2 ☐3 ☐4 ☐5	**78.**	the lack of support services for clients

How often have you experienced this factor while delivering/receiving services?

1 = None of the time; 2 = Very rarely; 3 = Some of the time; 4 = Most of the time; 5= All of the time

☐1 ☐2 ☐3 ☐4 ☐5	**79.**	the lack of support services for families
☐1 ☐2 ☐3 ☐4 ☐5	**80.**	the lack of summer support programs for clients
☐1 ☐2 ☐3 ☐4 ☐5	**81.**	the lack of summer support programs for families
☐1 ☐2 ☐3 ☐4 ☐5	**82.**	state legislators' limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**83.**	service providers' limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**84.**	families' limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**85.**	the general public's limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**86.**	low wages for service providers
☐1 ☐2 ☐3 ☐4 ☐5	**87.**	the lack of crisis services in locations that are easily accessible to clients
☐1 ☐2 ☐3 ☐4 ☐5	**88.**	the lack of inpatient crisis stabilization services
☐1 ☐2 ☐3 ☐4 ☐5	**89.**	limitations created by inconsistencies in agency confidentiality policies
☐1 ☐2 ☐3 ☐4 ☐5	**90.**	the lack of communication among agencies
☐1 ☐2 ☐3 ☐4 ☐5	**91.**	the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization
☐1 ☐2 ☐3 ☐4 ☐5	**92.**	understaffing
☐1 ☐2 ☐3 ☐4 ☐5	**93.**	the lack of appropriately trained staff
☐1 ☐2 ☐3 ☐4 ☐5	**94.**	the lack of agencies' knowledge of services provided by other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**95.**	limited availability of services in rural areas
☐1 ☐2 ☐3 ☐4 ☐5	**96.**	a lack of interagency training
☐1 ☐2 ☐3 ☐4 ☐5	**97.**	an inability to educate the rural population of available resources
☐1 ☐2 ☐3 ☐4 ☐5	**98.**	the lack of a clear understanding of which agencies are responsible for what problems
☐1 ☐2 ☐3 ☐4 ☐5	**99.**	the inconsistencies between allocation of staff resources and client needs
☐1 ☐2 ☐3 ☐4 ☐5	**100.**	the limited amount of time available to provide for the needs of clients and their families

How often have you experienced this factor while delivering/receiving services?

1 = None of the time; 2 = Very rarely; 3 = Some of the time; 4 = Most of the time; 5= All of the time

☐1 ☐2 ☐3 ☐4 ☐5	**101.**	the unwillingness of providers to alter services to better meet the needs of clients
☐1 ☐2 ☐3 ☐4 ☐5	**102.**	service duplication
☐1 ☐2 ☐3 ☐4 ☐5	**103.**	the lack of local public awareness campaigns for children's mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**104.**	the lack of local public awareness campaigns for children's mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**105.**	the inability to spend the necessary amount of time with each individual case
☐1 ☐2 ☐3 ☐4 ☐5	**106.**	the lack of funding for collaborative projects
☐1 ☐2 ☐3 ☐4 ☐5	**107.**	the unwillingness of agencies to accept responsibility for the difficult cases
☐1 ☐2 ☐3 ☐4 ☐5	**108.**	the disconnect between current funding streams and client needs
☐1 ☐2 ☐3 ☐4 ☐5	**109.**	the ability to find funding to meet the needs of individual counties
☐1 ☐2 ☐3 ☐4 ☐5	**110.**	the lack of funding to provide adequate services to clients
☐1 ☐2 ☐3 ☐4 ☐5	**111.**	high caseloads
☐1 ☐2 ☐3 ☐4 ☐5	**112.**	the unwillingness of schools to cooperate with social service providers
☐1 ☐2 ☐3 ☐4 ☐5	**113.**	the lack of communication among service providers
☐1 ☐2 ☐3 ☐4 ☐5	**114.**	the lack of advocates at the state level
☐1 ☐2 ☐3 ☐4 ☐5	**115.**	the lack of community-based parenting classes
☐1 ☐2 ☐3 ☐4 ☐5	**116.**	inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services
☐1 ☐2 ☐3 ☐4 ☐5	**117.**	the lack of mental health services for clients who don't have a payer source
☐1 ☐2 ☐3 ☐4 ☐5	**118.**	the lack of prevention services

APPENDIX I- RESPONSE RATING SHEET

Response Rating Sheet

Interorganizational Relationships Study

_____

How would you characterize this factor?

1 = Very discouraging; 2 = Discouraging; 3 = Neither discouraging, nor encouraging; 4 = Encouraging; 5= Very encouraging

☐1 ☐2 ☐3 ☐4 ☐5	**1.**	the tendency of service providers to not look outside the box for possible answers or solutions to client issues
☐1 ☐2 ☐3 ☐4 ☐5	**2.**	the limited number of service providers for clients
☐1 ☐2 ☐3 ☐4 ☐5	**3.**	the limited number of local out-of-home placements for clients
☐1 ☐2 ☐3 ☐4 ☐5	**4.**	the high number of at-risk students compared to the limited time available to serve them
☐1 ☐2 ☐3 ☐4 ☐5	**5.**	the high number of at-risk students compared to the limited resources available to serve them
☐1 ☐2 ☐3 ☐4 ☐5	**6.**	the willingness of the client to participate with service providers
☐1 ☐2 ☐3 ☐4 ☐5	**7.**	the willingness of the client's parents to participate with service providers
☐1 ☐2 ☐3 ☐4 ☐5	**8.**	the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions
☐1 ☐2 ☐3 ☐4 ☐5	**9.**	limited access to client transportation
☐1 ☐2 ☐3 ☐4 ☐5	**10.**	current collaborative efforts via Community Resource Coordination Group (CRCG)
☐1 ☐2 ☐3 ☐4 ☐5	**11.**	current collaborative efforts via CASA (Court Appointed Special Advocates)
☐1 ☐2 ☐3 ☐4 ☐5	**12.**	current collaborative efforts via Nacogdoches Safe and Drug Free
☐1 ☐2 ☐3 ☐4 ☐5	**13.**	the client's ability to pay for services
☐1 ☐2 ☐3 ☐4 ☐5	**14.**	the lack of access to service providers within close proximity to rural areas
☐1 ☐2 ☐3 ☐4 ☐5	**15.**	service providers' limited familiarity with services
☐1 ☐2 ☐3 ☐4 ☐5	**16.**	families' limited familiarity with services
☐1 ☐2 ☐3 ☐4 ☐5	**17.**	the lack of follow through with services from families
☐1 ☐2 ☐3 ☐4 ☐5	**18.**	the lack of follow through with services from professionals

How would you characterize this factor?

1 = Very discouraging; 2 = Discouraging; 3 = Neither discouraging, nor encouraging; 4 = Encouraging; 5= Very encouraging

☐1 ☐2 ☐3 ☐4 ☐5	**19.**	the unwillingness of Medicaid to provide comprehensive coverage to clients
☐1 ☐2 ☐3 ☐4 ☐5	**20.**	the lack of consequences for parents who are not actively involved in services for their children
☐1 ☐2 ☐3 ☐4 ☐5	**21.**	the lack of support groups to help parents develop the skills they need to help their child
☐1 ☐2 ☐3 ☐4 ☐5	**22.**	the lack of community-based mentors to work with the child and service providers
☐1 ☐2 ☐3 ☐4 ☐5	**23.**	the lack of school-based mentors to work with the child and service providers
☐1 ☐2 ☐3 ☐4 ☐5	**24.**	current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)
☐1 ☐2 ☐3 ☐4 ☐5	**25.**	the lack of school-based resources to serve children identified as LD (learning disabled)
☐1 ☐2 ☐3 ☐4 ☐5	**26.**	the lack of school-based resources to serve children identified as ED (emotionally disturbed)
☐1 ☐2 ☐3 ☐4 ☐5	**27.**	the distances families have to travel in order to receive services
☐1 ☐2 ☐3 ☐4 ☐5	**28.**	the tendency of agencies to work against each other instead of together
☐1 ☐2 ☐3 ☐4 ☐5	**29.**	Memorandums of Understanding (MOUs)
☐1 ☐2 ☐3 ☐4 ☐5	**30.**	interagency staff meetings
☐1 ☐2 ☐3 ☐4 ☐5	**31.**	the lack of financial support available in the community to support service delivery
☐1 ☐2 ☐3 ☐4 ☐5	**32.**	the willingness of clients to make substantive changes recommended by service providers
☐1 ☐2 ☐3 ☐4 ☐5	**33.**	the willingness of parents to make substantive changes recommended by service providers
☐1 ☐2 ☐3 ☐4 ☐5	**34.**	the willingness of families to make substantive changes recommended by service providers
☐1 ☐2 ☐3 ☐4 ☐5	**35.**	the use of mutual (interagency) training sessions to clarify agency policies

How would you characterize this factor?

1 = Very discouraging; 2 = Discouraging; 3 = Neither discouraging, nor encouraging; 4 = Encouraging; 5= Very encouraging

☐1 ☐2 ☐3 ☐4 ☐5	**36.**	the use of mutual (interagency) training sessions to clarify agency responsibilities
☐1 ☐2 ☐3 ☐4 ☐5	**37.**	the limited availability of services in the local community
☐1 ☐2 ☐3 ☐4 ☐5	**38.**	the tendency to rush to judge clients and their problems because of the opinions of entities involved with the clients
☐1 ☐2 ☐3 ☐4 ☐5	**39.**	decentralized client services
☐1 ☐2 ☐3 ☐4 ☐5	**40.**	centralized client services
☐1 ☐2 ☐3 ☐4 ☐5	**41.**	the lack of familiarity among service providers with the nature of rural areas
☐1 ☐2 ☐3 ☐4 ☐5	**42.**	reluctance of agencies to engage in staffings for common clients
☐1 ☐2 ☐3 ☐4 ☐5	**43.**	reluctance of agencies to communicate with one another
☐1 ☐2 ☐3 ☐4 ☐5	**44.**	the limited understanding of the policies of other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**45.**	the limited understanding of the procedures of other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**46.**	the limited understanding of the responsibilities of other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**47.**	the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)
☐1 ☐2 ☐3 ☐4 ☐5	**48.**	the high turnover rate of service providers
☐1 ☐2 ☐3 ☐4 ☐5	**49.**	the need for more home-based (in-home) services
☐1 ☐2 ☐3 ☐4 ☐5	**50.**	too much emphasis on paperwork
☐1 ☐2 ☐3 ☐4 ☐5	**51.**	the knowledge of available services
☐1 ☐2 ☐3 ☐4 ☐5	**52.**	the lack of community based aftercare services to support clients once they are released from an out-of-home placement
☐1 ☐2 ☐3 ☐4 ☐5	**53.**	the ability of agencies to work together to serve the client and family
☐1 ☐2 ☐3 ☐4 ☐5	**54.**	the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)
☐1 ☐2 ☐3 ☐4 ☐5	**55.**	the degree to which agencies will allow for creativity in working with clients and their families

How would you characterize this factor?

1 = Very discouraging; 2 = Discouraging; 3 = Neither discouraging, nor encouraging; 4 = Encouraging; 5= Very encouraging

☐1 ☐2 ☐3 ☐4 ☐5	**56.**	familiarity with the processes of other agencies involved with the client
☐1 ☐2 ☐3 ☐4 ☐5	**57.**	mutual respect among agencies involved in delivering services to the client
☐1 ☐2 ☐3 ☐4 ☐5	**58.**	openness to the views of other agencies involved in delivering services to the client
☐1 ☐2 ☐3 ☐4 ☐5	**59.**	openness to the approaches of other agencies involved in delivering services to the client
☐1 ☐2 ☐3 ☐4 ☐5	**60.**	the ability of agencies to start where the client is
☐1 ☐2 ☐3 ☐4 ☐5	**61.**	the ability of service providers to start where the client is
☐1 ☐2 ☐3 ☐4 ☐5	**62.**	limited coverage of health insurance for mental health issues
☐1 ☐2 ☐3 ☐4 ☐5	**63.**	limited access to health insurance for clients
☐1 ☐2 ☐3 ☐4 ☐5	**64.**	the distance clients must travel to access services
☐1 ☐2 ☐3 ☐4 ☐5	**65.**	the lack of communication between the school district and parents
☐1 ☐2 ☐3 ☐4 ☐5	**66.**	the lack of cooperation between the school district and mental health service providers
☐1 ☐2 ☐3 ☐4 ☐5	**67.**	the limited amount of time allowed by school districts for mental health service providers to meet with clients
☐1 ☐2 ☐3 ☐4 ☐5	**68.**	the unwillingness of school districts to allow mental health service providers to meet with clients at school
☐1 ☐2 ☐3 ☐4 ☐5	**69.**	the lack of family therapy services for mental health clients
☐1 ☐2 ☐3 ☐4 ☐5	**70.**	the lack of parent involvement with their children
☐1 ☐2 ☐3 ☐4 ☐5	**71.**	the limited amount of time available per client due to service delivery expectations
☐1 ☐2 ☐3 ☐4 ☐5	**72.**	the lack of local funding for mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**73.**	the lack of state funding for mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**74.**	the lack of federal funding for mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**75.**	shorter stays for inpatient psychiatric services
☐1 ☐2 ☐3 ☐4 ☐5	**76.**	limited Medicaid coverage for inpatient psychiatric services

How would you characterize this factor?

1 = Very discouraging; 2 = Discouraging; 3 = Neither discouraging, nor encouraging; 4 = Encouraging; 5= Very encouraging

☐1 ☐2 ☐3 ☐4 ☐5	**77.**	limited insurance coverage for inpatient psychiatric services
☐1 ☐2 ☐3 ☐4 ☐5	**78.**	the lack of support services for clients
☐1 ☐2 ☐3 ☐4 ☐5	**79.**	the lack of support services for families
☐1 ☐2 ☐3 ☐4 ☐5	**80.**	the lack of summer support programs for clients
☐1 ☐2 ☐3 ☐4 ☐5	**81.**	the lack of summer support programs for families
☐1 ☐2 ☐3 ☐4 ☐5	**82.**	state legislators' limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**83.**	service providers' limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**84.**	families' limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**85.**	the general public's limited understanding of mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**86.**	low wages for service providers
☐1 ☐2 ☐3 ☐4 ☐5	**87.**	the lack of crisis services in locations that are easily accessible to clients
☐1 ☐2 ☐3 ☐4 ☐5	**88.**	the lack of inpatient crisis stabilization services
☐1 ☐2 ☐3 ☐4 ☐5	**89.**	limitations created by inconsistencies in agency confidentiality policies
☐1 ☐2 ☐3 ☐4 ☐5	**90.**	the lack of communication among agencies
☐1 ☐2 ☐3 ☐4 ☐5	**91.**	the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization
☐1 ☐2 ☐3 ☐4 ☐5	**92.**	understaffing
☐1 ☐2 ☐3 ☐4 ☐5	**93.**	the lack of appropriately trained staff
☐1 ☐2 ☐3 ☐4 ☐5	**94.**	the lack of agencies' knowledge of services provided by other agencies
☐1 ☐2 ☐3 ☐4 ☐5	**95.**	limited availability of services in rural areas
☐1 ☐2 ☐3 ☐4 ☐5	**96.**	a lack of interagency training
☐1 ☐2 ☐3 ☐4 ☐5	**97.**	an inability to educate the rural population of available resources
☐1 ☐2 ☐3 ☐4 ☐5	**98.**	the lack of a clear understanding of which agencies are responsible for what problems

How would you characterize this factor?

1 = Very discouraging; 2 = Discouraging; 3 = Neither discouraging, nor encouraging; 4 = Encouraging; 5= Very encouraging

☐1 ☐2 ☐3 ☐4 ☐5	**99.**	the inconsistencies between allocation of staff resources and client needs
☐1 ☐2 ☐3 ☐4 ☐5	**100.**	the limited amount of time available to provide for the needs of clients and their families
☐1 ☐2 ☐3 ☐4 ☐5	**101.**	the unwillingness of providers to alter services to better meet the needs of clients
☐1 ☐2 ☐3 ☐4 ☐5	**102.**	service duplication
☐1 ☐2 ☐3 ☐4 ☐5	**103.**	the lack of local public awareness campaigns for children's mental health disorders
☐1 ☐2 ☐3 ☐4 ☐5	**104.**	the lack of local public awareness campaigns for children's mental health services
☐1 ☐2 ☐3 ☐4 ☐5	**105.**	the inability to spend the necessary amount of time with each individual case
☐1 ☐2 ☐3 ☐4 ☐5	**106.**	the lack of funding for collaborative projects
☐1 ☐2 ☐3 ☐4 ☐5	**107.**	the unwillingness of agencies to accept responsibility for the difficult cases
☐1 ☐2 ☐3 ☐4 ☐5	**108.**	the disconnect between current funding streams and client needs
☐1 ☐2 ☐3 ☐4 ☐5	**109.**	the ability to find funding to meet the needs of individual counties
☐1 ☐2 ☐3 ☐4 ☐5	**110.**	the lack of funding to provide adequate services to clients
☐1 ☐2 ☐3 ☐4 ☐5	**111.**	high caseloads
☐1 ☐2 ☐3 ☐4 ☐5	**112.**	the unwillingness of schools to cooperate with social service providers
☐1 ☐2 ☐3 ☐4 ☐5	**113.**	the lack of communication among service providers
☐1 ☐2 ☐3 ☐4 ☐5	**114.**	the lack of advocates at the state level
☐1 ☐2 ☐3 ☐4 ☐5	**115.**	the lack of community-based parenting classes
☐1 ☐2 ☐3 ☐4 ☐5	**116.**	inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services
☐1 ☐2 ☐3 ☐4 ☐5	**117.**	the lack of mental health services for clients who don't have a payer source

How would you characterize this factor?

1 = Very discouraging; 2 = Discouraging; 3 = Neither discouraging, nor encouraging; 4 = Encouraging; 5= Very encouraging

☐1 ☐2 ☐3 ☐4 ☐5 **118.** the lack of prevention services

APPENDIX J- BRIDGING ANALYSIS

#	Cluster/Statement	Value
	Cluster 1: Service Delivery	
54.	the ability of agencies to work together to resolve issues in the client's environment that affect his/her ability to function (such as issues in the family, peer group, school, community, etc.)	.00
57.	mutual respect among agencies involved in delivering services to the client	.01
28.	the tendency of agencies to work against each other instead of together	.02
59.	openness to the approaches of other agencies involved in delivering services to the client	.02
58.	openness to the views of other agencies involved in delivering services to the client	.02
43.	reluctance of agencies to communicate with one another	.03
42.	reluctance of agencies to engage in staffings for common clients	.04
30.	interagency staff meetings	.04
98.	the lack of a clear understanding of which agencies are responsible for what problems	.04
36.	the use of mutual (interagency) training sessions to clarify agency responsibilities	.05
44.	the limited understanding of the policies of other agencies	.06
35.	the use of mutual (interagency) training sessions to clarify agency policies	.06
46.	the limited understanding of the responsibilities of other agencies	.07
53.	the ability of agencies to work together to serve the client and family	.07
45.	the limited understanding of the procedures of other agencies	.08
10.	current collaborative efforts via Community Resource Coordination Group (CRCG)	.10
89.	limitations created by inconsistencies in agency confidentiality policies	.13
56.	familiarity with the processes of other agencies involved with the client	.13
11.	current collaborative efforts via CASA (Court Appointed Special Advocates)	.14
12.	current collaborative efforts via Nacogdoches Safe and Drug Free	.17
113.	the lack of communication among service providers	.19
8.	the need for open communication regarding the sharing of ideas to serve children outside of the regularly scheduled therapy sessions	.20
90.	the lack of communication among agencies	.23
107.	the unwillingness of agencies to accept responsibility for the difficult cases	.26
24.	current collaborative efforts supported by the Special Needs Diversionary Program (SNDP)	.32
102.	service duplication	.36
101.	the unwillingness of providers to alter services to better meet the needs of clients	.37
55.	the degree to which agencies will allow for creativity in working with clients and their families	.39
96.	a lack of interagency training	.39
29.	Memorandums of Understanding (MOUs)	.39
1.	the tendency of service providers to not look outside the box for possible answers or solutions to client issues	.40
94.	the lack of agencies' knowledge of services provided by other agencies	.42
83.	service providers' limited understanding of mental health disorders	.46
15.	service providers' limited familiarity with services	.51
60.	the ability of agencies to start where the client is	.52

#	Cluster/Statement	Value
99.	the inconsistencies between allocation of staff resources and client needs	.54
18.	the lack of follow through with services from professionals	.61
38.	the tendency to rush to judge clients and their problems because of the opinions of entities involved with the client	.63
	Cluster Average	***.22***
	Standard Deviations	***.19***
	Cluster 2: Availability of Services	
37.	the limited availability of services in the local community	.23
87.	the lack of crisis services in locations that are easily accessible to clients	.24
52.	the lack of community based aftercare services to support clients once they are released from an out-of-home placement	.26
49.	the need for more home-based (in-home) services	.27
118.	the lack of prevention services	.28
95.	limited availability of services in rural areas	.30
80.	the lack of summer support programs for clients	.30
91.	the lack of out of home services for children who do not qualify for juvenile detention or psychiatric hospitalization	.30
69.	the lack of family therapy services for mental health clients	.31
81.	the lack of summer support programs for families	.31
115.	the lack of community-based parenting classes	.31
88.	the lack of inpatient crisis stabilization services	.32
64.	the distance clients must travel to access services	.33
3.	the limited number of local out-of-home placements for clients	.33
78.	the lack of support services for clients	.35
14.	the lack of access to service providers within close proximity to rural areas	.36
27.	the distances families have to travel in order to receive services	.36
22.	the lack of community-based mentors to work with the child and service providers	.37
79.	the lack of support services for families	.38
9.	limited access to client transportation	.39
2.	the limited number of service providers for clients	.40
21.	the lack of support groups to help parents develop the skills they need to help their child	.42
5.	the high number of at-risk students compared to the limited resources available to serve them	.77
	Cluster Average	***.34***
	Standard Deviations	***.10***
	Cluster 3: Organizational Factors	
39.	decentralized client services	.50
71.	the limited amount of time available per client due to service delivery expectations	.50
92.	understaffing	.52
50.	too much emphasis on paperwork	.57
40.	centralized client services	.59

#	Cluster/Statement	Value
100.	the limited amount of time available to provide for the needs of clients and their families	.60
111.	high caseloads	.63
105.	the inability to spend the necessary amount of time with each individual case	.64
93.	the lack of appropriately trained staff	.64
86.	low wages for service providers	.97
41.	the lack of familiarity among service providers with the nature of rural areas	.68
61.	the ability of service providers to start where the client is	.69
48.	the high turnover rate of service providers	.74
	Cluster Average	***.61***
	Standard Deviations	***.07***
	Cluster 4: Public Schools and Public Awareness	
4.	the high number of at-risk students compared to the limited time available to serve them	.56
108.	the disconnect between current funding streams and client needs	.59
25.	the lack of school-based resources to serve children identified as LD (learning disabled)	.69
66.	the lack of cooperation between the school district and mental health service providers	.71
112.	the unwillingness of schools to cooperate with social service providers	.71
68.	the unwillingness of school districts to allow mental health service providers to meet with clients at school	.71
26.	the lack of school-based resources to serve children identified as ED (emotionally disturbed)	.74
114.	the lack of advocates at the state level	.75
67.	the limited amount of time allowed by school districts for mental health service providers to meet with clients	.86
65.	the lack of communication between the school district and parents	.86
103.	the lack of local public awareness campaigns for children's mental health disorders	.86
85.	the general public's limited understanding of mental health disorders	.86
51.	the knowledge of available services	.86
	Cluster Average	***.75***
	Standard Deviations	***.10***
	Cluster 5: Families	
7.	the willingness of the client's parents to participate with service providers	.56
33.	the willingness of parents to make substantive changes recommended by service providers	.56
34.	the willingness of families to make substantive changes recommended by service providers	.60
20.	the lack of consequences for parents who are not actively involved in services for their children	.65
82.	state legislators' limited understanding of mental health disorders	.67
6.	the willingness of the client to participate with service providers	.70
104.	the lack of local public awareness campaigns for children's mental health services	.73

#	Cluster/Statement	Value
32.	the willingness of clients to make substantive changes recommended by service providers	.74
84.	families' limited understanding of mental health disorders	.77
16.	families' limited familiarity with services	.80
70.	the lack of parent involvement with their children	.81
17.	the lack of follow through with services from families	.87
97.	an inability to educate the rural population of available resources	.88
23.	the lack of school-based mentors to work with the child and service providers	1.00
	Cluster Average	***.74***
	Standard Deviations	***.12***
	Cluster 6: Funding	
63.	limited access to health insurance for clients	.31
76.	limited Medicaid coverage for inpatient psychiatric services	.32
19.	the unwillingness of Medicaid to provide comprehensive coverage to clients	.32
77.	limited insurance coverage for inpatient psychiatric services	.32
62.	limited coverage of health insurance for mental health issues	.34
31.	the lack of financial support available in the community to support service delivery	.35
73.	the lack of state funding for mental health services	.38
13.	the client's ability to pay for services	.39
72.	the lack of local funding for mental health services	.39
47.	the lack of funding to support mandated activities of Community Resource Coordination Groups (CRCGs)	.40
117.	the lack of mental health services for clients who don't have a payer source	.41
74.	the lack of federal funding for mental health services	.41
109.	the ability to find funding to meet the needs of individual counties	.42
110.	the lack of funding to provide adequate services to clients	.43
75.	shorter stays for inpatient psychiatric services	.46
116.	inconsistencies in aftercare services for clients who were discharged from state inpatient psychiatric services versus those who were discharged from private inpatient psychiatric services	.48
106.	the lack of funding for collaborative projects	.48
	Cluster Average	***.39***
	Standard Deviations	***.05***

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VITA

Haskell Stephen Cooper was born in Dallas, Texas on January 25, 1972, the son of Judith Ann Cooper and Hayden Haskell Cooper. After completing his work at Garland High School, Garland, Texas, in 1989, he entered Richland College and earned an Associate of Arts and Sciences in May 1991. He attended Stephen F. Austin State University from 1991 to 1993 and earned a Bachelor of Science in December 1993. During the following years, he was employed in law enforcement and mental health services. In August 1996 he returned to Stephen F. Austin State University as a graduate student and completed his Master of Social Work in May 1999. After graduation, he continued to work as a provider of children's mental health services and later accepted a position as the Clinical Director of a wilderness based residential treatment program for adolescent girls. In August 2001, he accepted a faculty position in the School of Social Work at Stephen F. Austin State University. He has maintained his faculty position there while pursuing a doctoral degree at The University of Texas at Austin, which he began in June 2001.

Permanent Address: 313 County Road 2152, Nacogdoches, Texas 75965

This dissertation was typed by the author.